

Kaiser Permanente for Individuals and Families Membership Agreement and Evidence of Coverage

SECTION 1: Introduction to Your Kaiser Permanente Health Plan

Welcome to Kaiser Permanente

This health benefit Plan is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (further referred to as “Health Plan,” “we,” “us,” “our” and “Kaiser Permanente.” throughout this Agreement). Kaiser Permanente provides you with many resources to support your health and wellbeing. This Membership Agreement and Evidence of Coverage (EOC) is one of them. It provides you with an overview of your Health Plan, including the benefits you are entitled to, how to get care, what services are covered and what part of the costs of your care you will have to pay.

We ask that you review this Agreement in full and contact us with any questions you may have. Member Services representatives are ready and available to assist you Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You may also visit our website, www.kp.org to schedule an appointment, select a Plan Provider, choose or change your Primary Care Plan Physician, access valuable wellness tips and find answers to frequently asked questions.

Thank you for enrolling with Kaiser Permanente. We look forward to the opportunity to help you live a happier, healthier life!

Our Commitment to Diversity and Nondiscrimination

Diversity, inclusion and culturally competent medical care are defining characteristics of Kaiser Permanente. We champion the cause of inclusive care – care that is respectful of, and sensitive to the unique values, ideals and traditions of the cultures represented in our population. Our diverse workforce reflects the diversity of the people in the communities we serve.

We do not discriminate in our employment practices or the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or intellectual disability.

About This Agreement

Once you are enrolled in this Plan, you become a Member of Kaiser Permanente. A Member may be a Subscriber and/or any eligible Dependents who are enrolled in a Kaiser Permanente for Individuals and Families Plan. Members are sometimes referred to by the terms “you” and “your.”

Under no circumstances should the terms “you” or “your” be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

Important Terms

Some terms in this Agreement are capitalized. They have special meanings. Please see the *Important Terms You Should Know* section to familiarize yourself with these terms.

Purpose of this Agreement

This Agreement serves two important purposes. It:

1. Is a legally binding contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; and

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2. Provides evidence of your health care coverage under this Kaiser Permanente Individuals and Families Membership Agreement.

Acceptance of Agreement

Payment of due Premium indicates to the Health Plan that a Subscriber or Financially Responsible Person accepts this Agreement in full. Acceptance of this Agreement confirms that a Subscriber or Financially Responsible Person and the Health Plan agree to all of the provisions contained within it.

Right to Reject Agreement

You may return this Agreement to the Health Plan within ten (10) days of receiving it if you feel the Agreement is not satisfactory for any reason. If you return this Agreement and it is received by us within ten (10) days, you will receive a full refund of paid Premium and the Agreement will be void and canceled. This right may not be exercised if any Member covered under the Agreement utilizes the Services of the Health Plan within the aforementioned ten (10)-day period.

Administration of Agreement

We may adopt reasonable policies, procedures and interpretations that promote the orderly and efficient administration of this Agreement.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, nor impair our right thereafter to require your strict performance of any provision.

Entire Contract

This Agreement replaces any earlier Agreement that may have been issued to you by us.

This Agreement constitutes the entire contract between you and us. This Agreement will only be modified as allowed or required by law. We may not amend this Agreement with respect to any matter, including rates.

No agent or other person, except an officer of the Health Plan, has the authority to:

1. Waive any conditions or restrictions of this Agreement;
2. Extend the time for paying required Premium; or
3. Bind the Health Plan in any way, verbally or otherwise, by:
 - a. Making any promise or representation; or
 - b. Giving or receiving any information.

No change in this Agreement will be considered valid unless recorded in a written amendment signed by an officer of the Health Plan and attached to this Agreement.

This Agreement is undersigned by us immediately below. Your signature is not required.

**KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.**



Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

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How Your Health Plan Works

The Health Plan provides health care Services to Members through an integrated medical care system, rather than reimbursement of expenses on a fee-for-service basis. Please keep this direct service nature in mind as you read this Agreement. Our integrated medical care system is made up of various entities. The relationship between them is explained immediately below.

Relations Among Parties Affected By This Agreement

Kaiser Permanente is comprised of three entities: the Health Plan, Medical Group and Plan Hospitals. Please note that:

1. The relationship between the Health Plan and Medical Group and between the Health Plan and Plan Hospitals are those of independent contractors;
2. Plan Providers and Plan Hospitals are not agents or employees of the Health Plan; and
3. Neither the Health Plan nor any employee of the Health Plan is an employee or agent of Plan Hospitals or Medical Group or any Plan Provider.

Additionally:

1. Plan Physicians maintain the physician-patient relationship with Members, and are solely responsible to Members for all medical Services; and
2. Plan Hospitals maintain the Hospital-patient relationship with Members and are solely responsible to Members for all Hospital Services.

Patient Information Obtained By Affected Parties

Patient-identifying information from Member medical records, and that is received by Plan Physicians or Plan Hospitals incident to the physician-patient or Hospital-patient relationship, is kept confidential. Patient-identifying information is not disclosed without the prior consent of a Member, except for use by the Health Plan, Plan Hospitals, Medical Group or Plan Physicians in relation to:

1. Administering this Agreement;
2. Complying with government requirements; and
3. Bona fide research or education.

Liability for Amounts Owed By the Health Plan

Members are not liable for any amounts owed to the Medical Group or Plan Hospitals by the Health Plan, as stipulated by contracts between these entities.

Kaiser Permanente for Individuals and Families Plan Services Overview

Health care Services are provided to you through an integrated medical care system using Plan Providers located in our state-of-the-art Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area.

Getting the care you need is easy. Health care Services are accessible at Plan Medical Centers, which are conveniently located throughout the Washington, D.C. and Baltimore Metropolitan Areas. At our Plan Medical Centers, we have integrated teams of specialists, nurses and technicians working alongside your Primary Care Plan Physician to support your health and wellbeing. Pharmacy, optical, laboratory and X-ray facilities are also available at many Plan Medical Centers.

Under this Agreement, you must receive Services from Plan Providers within our Service Area, except for:

1. Emergency Services, as described in *Section 3: Benefits, Exclusions and Limitations*;

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2. Urgent Care Services outside of our Service Area, as described in *Section 3: Benefits, Exclusions and Limitations*;
3. Continuity of Care for Members, as described in *Section 2: How to Get the Care You Need*;
4. Approved referrals, as described in *Section 2: How to Get the Care You Need* under the *Getting a Referral* provision, including referrals for Clinical Trials as described in *Section 3: Benefits, Exclusions and Limitations*.

Eligibility for a Kaiser Permanente Individuals and Families Plan

If you or your Dependent are entitled to Medicare Part A or enrolled in Medicare Part B, then you or your Dependent are ineligible for this Kaiser Permanente Individual and Families Plan.

Member Eligibility

Members may be accepted for enrollment and continuing coverage hereunder only upon meeting all of the applicable requirements below, which are set forth by the Health Plan or Exchange, depending on how you applied for coverage.

Subscribers

To be a Subscriber you must apply during an annual open enrollment period or a special enrollment period, both of which are described within this section of your EOC.

Dependents

To be a Dependent you must be:

1. The Subscriber's Spouse or Domestic Partner.
2. A Dependent child of the Subscriber or the Subscriber's Spouse or Domestic Partner who is under the limiting age of 26. A Dependent child under the limiting age is defined as either:
 - a. A biological child, stepchild, lawfully adopted child or foster child placed for legal adoption with the Subscriber or the Subscriber's Spouse or Domestic Partner; or
 - b. An unmarried grandchild, or unmarried child under testamentary or court-appointed Guardianship of the Subscriber or the Subscriber's Spouse or Domestic Partner.
3. A Dependent child under the limiting age of 26 who is not a natural or adopted child, but for whom the Subscriber or the Subscriber's Spouse or Domestic Partner has received a court or administrative order.

An unmarried child who is covered as a Dependent when they reach the limiting age under requirement #2 above may continue coverage if he/she is incapable of self-support by reason of intellectual disability or physical handicap. The child must be chiefly dependent upon the Subscriber or the Subscriber's Spouse or Domestic Partner for support and maintenance. Proof of incapacity and dependency must be provided when requested by the Health Plan.

Subscribers who apply for coverage through the Health Plan must notify the Health Plan of any change in eligibility of a Dependent for any reason other than the child becomes age 26.

Eligible children of the Subscriber or Subscriber's Spouse or Domestic Partner who live outside of our Service Area are eligible for Dependent coverage. However, the only covered Services outside of our Service Area are:

1. Emergency Services;
2. Urgent Care Services; and

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3. Services received in connection with an approved referral, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

Eligibility for Catastrophic Coverage Plans

This provision applies only to Members with catastrophic coverage. Some Plans offer catastrophic coverage, depending on Member age and other factors. Review the Cost Sharing information provided in this Agreement to determine whether or not you are enrolled in catastrophic coverage.

Member Eligibility

In order to enroll and to continue enrollment in our catastrophic Plan, you and each Dependent must individually meet one of the following requirements:

1. You and your Dependent(s) must not have reached age 30 before January 1 of the Calendar Year. If you reach age 30 on or after January 1, your catastrophic coverage will continue until the end of the current Calendar Year. However, you will no longer meet the age qualification for catastrophic coverage beginning January 1 of the next year; or
2. The Health Plan has certified that for the first day of the current Calendar Year, you and/or your Dependent are exempt from the shared responsibility payment for the reasons identified in Internal Revenue Code Section 5000A(e)(1)(relating to individuals without affordable coverage) or 5000A(e)(5) (relating to individuals with hardships).

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you with quality health care Services. In the spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care Services.

Member Rights

As a Member of Kaiser Permanente, you or your Authorized Representative, Parent/Guardian or a Financially Responsible Person, as applicable, have the right to:

1. **Receive information that empowers you to be involved in health care decision making. This includes the right to:**
 - a. Actively participate in discussions and decisions regarding your health care options;
 - b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved – no matter what the cost is or what your benefits are;
 - c. Receive relevant information and education that helps promote your safety in the course of treatment;
 - d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information;
 - e. Refuse treatment, providing you accept the responsibility and consequences of your decision;
 - f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a Durable Power of Attorney for Health Care, Living Will, or other health care treatment directive. You can rescind or modify these documents at any time;

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- g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects; and
 - h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on applicable federal and state law to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. The Member or Member's Authorized Representative will be asked to provide written permission before a Member's records are released, unless otherwise permitted by law.
2. **Receive information about Kaiser Permanente and your Plan. This includes the right to:**
- a. Receive the information you need to choose or change your Primary Care Plan Physician, including the name, professional level and credentials of the doctors assisting or treating you;
 - b. Receive information about Kaiser Permanente, our Services, our practitioners and Providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's Member rights and responsibility policies;
 - c. Receive information about financial arrangements with physicians that could affect the use of Services you might need;
 - d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed;
 - e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area;
 - f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered; and
 - g. File a complaint, Grievance or Appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.
3. **Receive professional care and Service. This includes the right to:**
- a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring and professional manner;
 - b. Have your medical care, medical records and protected health information (PHI) handled confidentially and in a way that respects your privacy;
 - c. Be treated with respect and dignity;
 - d. Request that a staff member be present as a chaperone during medical appointments or tests;
 - e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any intellectual or physical disability you may have;
 - f. Request interpreter Services in your primary language at no charge; and
 - g. Receive health care in facilities that are environmentally safe and accessible to all.

Member Responsibilities

As a Member of Kaiser Permanente, you or your Parent/Guardian, as applicable, are responsible to:

1. **Promote your own good health:**

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- a. Be active in your health care and engage in healthy habits;
 - b. Select a Primary Care Plan Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics or Family Practice as your Primary Care Plan Physician. You may also choose a personal OB/GYN in addition to Primary Care Plan Physician;
 - c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you;
 - d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals;
 - e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment;
 - f. Do your best to improve your health by following the treatment plan and instructions your Primary Care Plan Physician or health care professional recommends;
 - g. Schedule the health care appointments your Primary Care Plan Physician or health care professional recommends;
 - h. Keep scheduled appointments or cancel appointments with as much notice as possible; and
 - i. Inform us if you no longer live within the Plan Service Area.
2. **Know and understand your Plan and benefits:**
- a. Read about your health care benefits in this Agreement and become familiar with them. Call us when you have questions or concerns;
 - b. Pay your Plan Premium, and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible;
 - c. Let us know if you have any questions, concerns, problems or suggestions;
 - d. Inform us if you have any other health insurance or prescription drug coverage; and
 - e. Inform any network or nonparticipating provider from whom you receive care that you are enrolled in our Plan.
3. **Promote respect and safety for others:**
- a. Extend the same courtesy and respect to others that you expect when seeking health care Services; and
 - b. Assure a safe environment for other Members, staff and physicians by not threatening or harming others.

Health Savings Account-Qualified Plans

This provision only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A Health Savings Account is a tax-exempt account established under Section 223(d) of the Internal Revenue Code for the exclusive purpose of paying current and future Qualified Medical Expenses. Contributions to such an account are tax deductible, but in order to qualify for and make contributions to a Health Savings Account, a Member must be enrolled in a qualified High Deductible Health Plan.

A qualified High Deductible Health Plan provides health care coverage that includes an:

1. Individual Deductible of \$1,400.00 or greater and a family Deductible of \$2,800.00 or greater; and
2. Individual Out-of-Pocket Maximum of no more than \$6,900.00 and a family Out-of-Pocket Maximum of no more than \$13,800.00 in the current Calendar Year.

In a qualified High Deductible Health Plan, all Deductible, Copayment and Coinsurance amounts must be

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counted toward the Out-of-Pocket Maximum. Review the Cost Sharing information contained within this Agreement to see whether or not this Plan meets the High Deductible Health Plan requirements described in this paragraph. A Plan is a qualified High Deductible Health Plan only if it meets those requirements. Enrollment in a qualified High Deductible Health Plan is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Other requirements include the following prohibitions: The Member must not:

1. Be covered by other health coverage that is not also a Health Savings Account-qualified plan, with certain exceptions;
2. Enrolled in Medicare; and/or
3. Able to be claimed as a Dependent on another person's tax return.

Please note that the tax references contained in this Agreement relate to federal income tax only. The tax treatment of Health Savings Account contributions and distributions under a state's income tax laws may differ from the federal tax treatment. Kaiser Permanente does not provide tax advice. Contact your financial or tax advisor for more information about your eligibility for a Health Savings Account or to obtain tax advice.

Payment of Premium

In consideration of the timely Premium paid to the Health Plan or Exchange, we agree to arrange health care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement.

This Plan is contributory in that the Subscriber, on behalf of his/herself and any applicable Dependents, or a Financially Responsible Person, on behalf of an eligible child Member, is responsible for payment of all required Premium. Premium is due directly to Health Plan no later than the 1st day of the coverage month.

The Financially Responsible person may be a Parent/Guardian, but sometimes they are different people. In the event that the Financially Responsible Person and Parent/Guardian:

1. Are not the same person, then this Agreement is a legally binding contract between the:
 - a. Health Plan;
 - b. Financially Responsible Person; and
 - c. Parent/Guardian who holds the legal authority to make medical decisions for a Member under age 18 or who is age 18 or older, but incapable of making medical decisions by reason of mental incapacity.
2. Is the same person, he/she shall be recognized as having the rights and responsibilities of both the Financially Responsible Person and the Parent/Guardian under this Agreement.

When requested by the Parent/Guardian, more than one (1) eligible child, when properly enrolled and for whom Premium has been paid, may be covered under this Agreement.

Only Members for whom the Health Plan has received the appropriate Premium Payments are entitled to coverage under this Agreement, except as provided in **Section 6: Extension of Benefits**, and then only for the period for which such Premium is received, in accordance with **Section 6: Termination Due to Nonpayment of Premium**.

The Premium due under this Agreement is determined by the Health Plan upon application for coverage. The Subscriber or Financially Responsible Person, as applicable, will be given at least seventy-five (75)

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days' notice of any Premium change. Please refer to *Amendment of Agreement* in this section for additional information.

Annual Enrollment Period and Effective Date of Coverage

There is an annual enrollment period during which Qualified Individuals may:

1. Enroll in this Plan;
2. Discontinue enrollment in this Plan; or
3. Change enrollment from this Plan to another Plan offered by us.

The annual enrollment period shall begin on November 1, 2019, and extend through December 15, 2019.

If a Qualified Individual enrolls in this Plan during the annual enrollment period for 2020, the effective date of coverage shall be January 1, 2020, for completed applications received on or before December 15, 2019.

Special Enrollment Periods Due to Triggering Events

When a triggering event occurs, a special enrollment period will be provided. If you and/or any Dependents are eligible to enroll in this Plan or another Plan offered by us during the special enrollment period, we will process your enrollment following your Plan selection and submission of any necessary information to confirm the occurrence of a triggering event. If we do not receive the Plan selection and any other required information necessary to confirm the triggering event in a timely manner, then no changes in enrollment can be made by us.

A triggering event when you or your Dependent:

1. Loses Minimum Essential Coverage. Loss of Minimum Essential Coverage includes, but is not limited to, loss of coverage due to the loss of:
 - a. Your job or a reduction in your working hours;
 - b. Individual coverage;
 - c. Medicare;
 - d. Certain Medicaid; and
 - e. Children's Health Insurance Program (CHIP) coverage.
 - i. **Note:** Loss of Minimum Essential Coverage does not include loss of coverage due to:
 - a) Failure to pay Premium in a timely manner, including COBRA Premium prior to expiration of COBRA coverage;
 - b) Rescission of coverage as specified in 45 C.F.R. §147.128; or
 - c) Voluntary termination of coverage by an individual.

The date of the loss of coverage is the last day you and/or your Dependent would have coverage under the previous plan or coverage.

2. Loses pregnancy-related coverage as described under section 1902(a)(10)(A)(i) (IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day that you and/or your Dependent would have pregnancy-related coverage.
3. Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act. This triggering event allows you a special enrollment period only once per Calendar Year. The date of the loss of coverage is the last day you and/or your Dependent would have medically needy coverage.

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4. Are enrolled in any non-Calendar Year group health plan or individual health plan coverage and such non-Calendar Year plan or policy year is ending, even if you and/or your Dependent have the option to renew that coverage. The date of the loss of coverage is the last day of the expiring non-Calendar Year plan.

Triggering events also occur when:

1. You gain or become a Dependent through:
 - a. Marriage (only applies if at least one (1) spouse was enrolled in an exchange plan at least one (1) day in the sixty (60) days before marriage, lived abroad for one (1) or more days in the sixty (60) days before marriage or is an American Indian or Alaskan Native);
 - b. Birth;
 - c. Adoption;
 - d. Placement for adoption;
 - e. Placement in foster care;
 - f. A child support order; or
 - g. Other court or administrative order.
2. You lose a Dependent or you are no longer considered to be a Dependent due to divorce or legal separation as defined by state law in the state where the divorce or legal separation occurs.
3. The Subscriber or a Dependent dies.
4. You or your Dependent gains access to a new Qualified Health Plan as a result of a permanent move or a recent release from incarceration.
5. You or your Dependent who is enrolled in this Plan are determined newly-eligible or ineligible for Advance Premium Tax Credit or have a change in eligibility for federal cost-sharing reductions.
6. Either you or your Dependent, while enrolled in an eligible employer-sponsored plan, becomes newly-eligible for Advance Premium Tax Credit because you or your Dependent will be ineligible for qualifying coverage in an employer-sponsored plan (in accordance with 26 CFR 1.36B-2(c)(3)). This includes loss of coverage as a result of the employer's discontinuation or change of available coverage within the next sixty (60) days, provided that you or your Dependent may terminate your existing coverage under the employer-sponsored plan.
7. You or your Dependent applies for coverage during the annual open enrollment period or following a triggering event and are assessed as potentially eligible for Medicaid or the CHIP but are determined to be ineligible for Medicaid or CHIP by the state Medicaid or CHIP agency either after the open enrollment period has ended or more than sixty (60) days after the qualifying event.
8. You or your Dependent demonstrates that a material error related to plan benefits, service area or premium was an influential factor in the decision to purchase a Qualified Health Plan.
9. You or your Dependent, including an unmarried victim within a household, are a victim of domestic abuse or spousal abandonment, enrolled in minimum essential coverage, and seeks to obtain coverage separate from the perpetrator of the abuse or abandonment. The Dependent of a victim of domestic abuse or spousal abandonment may enroll in coverage at the same time as the victim and on the same application as the victim.
10. You or your Dependent's enrollment or lack of enrollment in a Qualified Health Plan is evaluated and determined to be unintentional, inadvertent or erroneous.
11. You or your Dependent who is enrolled in this Plan adequately demonstrate that we have substantially violated a material provision of this Agreement.

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Length of Special Enrollment Periods

Based on the type of triggering event experienced by you or your Dependent (which are described above in *Special Enrollment Periods Due to Triggering Events*), your special enrollment period will last sixty (60) days from the date of the triggering event, except when:

1. You or your Dependent loses Minimum Essential Coverage, pregnancy-related or medically needy coverage, or if coverage under any non-Calendar Year group health plan or individual health insurance is ending;
2. You or your Dependent loses coverage in an employer-sponsored plan; or
3. You or your Dependent gains access to a new Qualified Health Plan as a result of a permanent move.

If any of the aforementioned events immediately above occurs, you have sixty (60) days prior to and sixty (60) days following the triggering event to enroll.

Effective Date for Special Enrollment Periods

If an individual enrolls as the result of a triggering event, the effective date of coverage shall be:

1. In the case of marriage or loss of Minimum Essential Coverage, the first day of the following month;
2. In the case of birth, adoption, placement for adoption or placement in foster care, the date of birth, adoption, placement for adoption or placement in foster care. The “date of adoption” means the earlier of:
 - a. A judicial decree of adoption; or
 - b. The assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive Parent.
3. In the case of a newly-eligible grandchild in court-ordered custody, the date the grandchild is placed in the custody of the Subscriber or the Subscriber’s Spouse.
4. In the case of a child who is newly-eligible as the result of a child support order or other court or administrative order received by the Subscriber or the Subscriber’s Spouse, the date of the court or administrative order.
5. In the case of a child who is newly-eligible as the result of a testamentary or court-appointed Guardianship, received by the Subscriber or the Subscriber’s Spouse, the date of the court or testamentary appointment.
6. In the case of an individual eligible for special enrollment when:
 - a. Enrollment or non-enrollment was unintentional, inadvertent or erroneous; and the result of an error by the Exchange, HHS or a non-Exchange entity; or
 - b. The Qualified Health Plan substantially violated a material provision of its Contract with the individual, the effective date is the first day of the following month when the application or change form is received by the Health Plan between the first and the 15th day of any month; and first day of the second following month when a selection is received by the Health Plan between the 16th and the last day of any month.
7. In the case of death, the first day of the following month following plan selection or, if permitted by the Health Plan.
8. For all other triggering events, the first day of the following month when the application or change form is received by the Health Plan between the first and the 15th day of any month; and first day

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of the second following month when a selection is received by the Health Plan between the 16th and the last day of any month.

Premium Payment Changes Due to Special Enrollments

Your Premium may change if you:

1. Choose a new Plan;
2. Switch to coverage other than self-only by adding Dependents; or
3. Reduce the number of covered Dependents.

Premium Payment Requirements for Special Open Enrollment Periods

When No Additional Premium is Required

If you experience a triggering event then enroll during a special enrollment period, coverage will be effective as of the date described above in the event that no additional Premium is required.

When Additional Premium is Due

If additional Premium is required following enrollment after you experience a triggering event, the Premium is due no later than the last day of the special enrollment period described above in order for us to provide coverage. If the premium is not paid prior to the end of the special enrollment period, coverage never becomes effective. The only exceptions are in the case of a triggering event involving:

1. Birth;
2. Adoption; and
3. Placement for adoption.

Under those circumstances, coverage will terminate as of the 31st day during the sixty (60)-day period if additional due Premium is not paid before expiration of the sixty (60)-day enrollment period mentioned above under *Effective Date for Special Enrollment Periods* in this section.

Notice of Your Effective Date of Coverage

The Health Plan will notify you and any enrolled Dependents of your effective date of coverage under this Plan based on the rules described above.

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SECTION 2: How to Get the Care You Need

Making and Cancelling Appointments and Who to Contact

At Kaiser Permanente, we are available to assist you in getting the care you need. Should you experience a medical condition or require assistance from us, please contact the appropriate number below.

Medical Emergencies

- **Call 911, where available, if you think you have a medical emergency.**

Medical Advice

- **Call us at 1-800-677-1112 if you are unsure of your condition and require immediate medical advice.** You should also call this number in the event that you have an emergency Hospital admission. We require notice within forty-eight (48) hours, or as soon as reasonably possible thereafter, of any emergency Hospital admission.

Making or Canceling Appointments

To make or cancel an appointment, please visit us online at www.kp.org.

You may also make or cancel an appointment by phone. To do so, please have your Kaiser Permanente identification card with you and contact us at 1-800-777-7904 or 711 (TTY). We are available to assist you 24/7.

If your Primary Care Plan Physician is not located at one of our Plan Medical Centers, you may need to contact his/her office directly for assistance making or canceling an appointment. The telephone number for their office is located on your Kaiser Permanente identification card.

Choosing or Changing Your Primary Care Plan Physician

We recommend that you choose a Primary Care Plan Physician if you have not done so already. For more information, see *Choosing Your Primary Care Plan Physician* in this section.

You may choose or change your Primary Care Plan Physician at any time, for any reason, by visiting www.kp.org/doctor. On the website, you can browse all doctor's profiles and select a doctor who matches your needs.

You may also choose or change your Primary Care Plan Physician by phone by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Customer Service:

We want you to be satisfied with your health care. Member Services representatives are available to assist you with questions about your Plan Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Member Services representatives are also available at most of our Plan medical offices. You may also ask your Primary Care Plan Physician or other health care professionals about problems you may have.

Advance Directives to Direct Your Care While Incapacitated

Advance directives are legal forms that help you control the kind of health care you will receive if you become very ill or unconscious. We ask that you please consider the benefits of completing a:

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1. Durable Power of Attorney for Health Care, which lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments; and
2. Living Will and the Natural Death Act Declaration to Physicians, which lets you write down your wishes about receiving life support and other treatment.

For additional information about advance directives, including how to obtain forms and instructions, visit us online at www.kp.org or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Receiving Health Care Services

To receive the Services covered under this Agreement, you must be a current Health Plan Member for whom Premium has been paid. Anyone who is not a Member will be billed for any Services we provide at Allowable Charges and claims for Emergency or Urgent Care Services from non-Plan Providers will be denied.

As a current Member under this Plan, we agree to arrange health care Services in accordance with the terms, conditions, limitations and exclusions of this Agreement. You may receive these Services and other benefits specified in this Agreement when provided, prescribed or directed by Plan Providers within our Service Area.

You have your choice of Plan Physicians and Facilities within our Service Area. Covered Services are available only from the Medical Group, Plan Facilities and in-Plan Skilled Nursing Facilities. Neither the Health Plan, Medical Group nor any Plan Physicians have any liability or obligation extending from any Service or benefit sought or received by a Member from any non-Plan:

1. Doctor;
2. Hospital;
3. Skilled Nursing Facility;
4. Person;
5. Institution; or
6. Organization, except when you:
 - a. Have a pre-authorized referral for the Services; or
 - b. Are covered under the *Emergency Services* or *Urgent Care Services* provisions in *Section 3: Benefits, Exclusions and Limitations*.

Emergency Services and Urgent Care Services, in addition to Services associated with pre-authorized referrals, are the only Services a Member may seek outside of the Service Area.

Your Kaiser Permanente Identification Card

Digital Kaiser Permanente Identification Card

Managing your health care is convenient with the Kaiser Permanente mobile app. The app gives you access to your digital Kaiser Permanente identification card, which allows you to check in for appointments, pick up prescriptions and provide your membership information, all from your smartphone. To access your digital Kaiser Permanente identification card:

1. Log into the Kaiser Permanente mobile app; and
2. Select “Member ID Card” from the menu options.

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Note: Verify that the Kaiser Permanente mobile app is available on your smartphone and create your login before arriving at your appointment. Additionally, the availability of the digital Kaiser Permanente identification card is limited to certain types of Plans and does not replace the physical card. Each Member will also receive a physical Kaiser Permanente identification card.

Using Your Kaiser Permanente Identification Card

Your Kaiser Permanente identification card is for identification purposes only. It contains your name, Medical Record Number and our contact information. When you visit a Plan Facility, please have both your Kaiser Permanente identification card and a valid photo ID with you. You will be asked to show both of them when checking in.

Your Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number.

If you need to replace your Kaiser Permanente identification card, or if we ever issue you more than one (1) Medical Record Number, please let us know by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Note: Allowing another person to use your ID card will result in forfeiture of your Kaiser Permanente identification card and may result in termination of your membership.

Choosing Your Primary Care Plan Physician

We highly encourage you to choose a Primary Care Plan Physician when you enroll. He or she will play an important role in coordinating your health care Services, including Hospital stays and referrals to specialists. Additionally, your Primary Care Plan Physician and Plan Providers will work as a team, along with you, to ensure continuity of care and medically appropriate courses of treatment.

Each Member in your family should select a Primary Care Plan Physician. If you do not select a Primary Care Plan Physician upon enrollment, we will assign you one near your home. You may select or change your Primary Care Plan Physician at any time by visiting us online at www.kp.org or contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Our Provider Directory is available online at www.kp.org and updated twice each month. A listing of all Primary Care Plan Physicians is also provided to you on an annual basis.

You may select a Primary Care Plan Physician, who is available to accept new Members, from the following areas: Internal medicine, family practice and pediatrics. Within pediatrics, you may select an allopathic or osteopathic pediatrician as the Primary Care Plan Physician for your child. In addition to selecting a Primary Care Plan Physician, Members may choose a Plan Physician who practices in the specialty of obstetrics or gynecology (OB/GYN) as their personal OB/GYN.

Getting a Referral

Our Plan Physicians offer primary medical, pediatric and OB/GYN care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology and other medical specialties. We have Plan Medical Centers and specialty facilities such as imaging centers, located within our Service Area. You will receive most of the covered Services that you routinely need at these facilities unless you have an approved referral to another Plan Provider.

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All referrals will be subject to review and approval, which is known as authorization, in accordance with the terms of this Agreement. We will notify you when our review is complete.

Receiving an Authorized Specialist or Hospital Referral

If your Plan Provider decides that you require covered Services from a Specialist, you will receive an authorized referral to a Plan Provider who specializes in the type of care you need.

In the event that the covered Services you need are not available from a Plan Provider, we may refer you to another provider. For more information, see *Referrals to Non-Plan Specialists and Non-Physician Specialists* below.

When you need authorized covered Services at a Plan Hospital, you will be referred to a Plan Hospital. We may direct that you receive the Hospital Services at a particular Plan Hospital so that we may better coordinate your care using Medical Group Plan Physicians and our electronic medical record system.

Post-Referral Services Not Covered

Any additional Services not specifically listed, and/or that are provided by a professional not named in the referral, are not authorized and will not be reimbursed.

If a non-Plan Provider for whom you have received an authorized referral recommends additional Services that are not indicated in that approved referral, advise your Plan Provider. He or she will work with you to determine whether those Services can be provided by a Plan Provider. Additional Services not specifically listed in the referral are not authorized and will not be reimbursed unless you have received a preauthorization for those Services.

Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires Specialty Services, your Primary Care Plan Physician may determine, in consultation with you and a Specialist, that you need continuing care from that Specialist. In such instances, your Primary Care Plan Physician will issue a standing referral to the Specialist.

If you have been diagnosed with cancer, Health Plan will allow your primary care Plan Physician to issue a standing referral to any Health Plan authorized oncologist or board-certified physician in pain management, as you choose.

A standing referral should be developed by the specialist, your Primary Care Plan Physician and you, and made in accordance with a written treatment plan consisting of covered Services. The treatment plan may limit the authorized number of Specialist visits and/or the period of time in which those Specialist visits are authorized. It may also require that the Specialist communicate regularly with your Primary Care Plan Physician regarding your treatment and health status.

Referrals to Non-Plan Specialists and Non-Physician Specialists

A Member may request a referral to a non-Plan Specialist or a non-physician Specialist if:

1. The Member has been diagnosed with a condition or disease that requires specialized health care Services or medical care; and
 - a. The Health Plan does not have a Plan Specialist or non-physicians Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease; or

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- b. The Health Plan cannot provide reasonable access to a Specialist or non-physician Specialist with the professional training and expertise to treat or provide health care Services for the condition or disease without unreasonable delay or travel.

You must have an approved written referral to the non-Plan Specialist or non-physician Specialist in order for the Health Plan to cover the Services. The Cost Share amounts for approved referral Services are the same as those required for Services provided by a Plan Provider.

If you are balance billed by a non-Plan physician or other non-Plan provider for authorized Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998

For more information on the payment or reimbursement of covered Services and how to file a claim, see *Section 5: Filing Claims, Appeals and Grievances*.

Services that Do Not Require a Referral

There are specific Services that do not require a referral from your Primary Care Plan Physician. However, you must obtain the care from a Plan Provider. These Services include:

1. An initial consultation for treatment of mental illness, emotional disorders and drug or alcohol abuse, when provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance to arrange and schedule these covered Services. The Behavioral Access Unit can be reached at 1-866-530-8778;
2. OB/GYN Services provided by an OB/GYN, a certified nurse-midwife or other Plan Provider authorized to provide OB/GYN Services, if the care is Medically Necessary, including the ordering of related, covered OB/GYN Services; and
3. Optometry Services.

For the most up-to-date list of Plan Medical Centers and Plan Providers, visit us online at www.kp.org. To request a Provider Directory, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Continuity of Care for Members

You may request to continue receiving health care Services for a period of at least ninety (90) days from the date of notification of the Plan Provider's termination from the Health Plan's provider panel, except when terminated for cause.

In addition, under the following special situations, Health Plan will continue to provide benefits for Plan Provider's care beyond the aforementioned period of ninety (90) days when you:

1. Have entered at least the second trimester of pregnancy at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at your option, through the provision of postpartum care; or
2. Are determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at your option, for the remainder of your life.

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Getting Emergency and Urgent Care Services

Emergency Services

Emergency Services are covered no matter when or where in the world they occur.

If you think you have a medical emergency, call 911, where available, or go to the nearest emergency room. For coverage information in the event of a medical emergency, including emergency benefits away from home, refer to *Emergency Services* in **Section 3: Benefits, Exclusions and Limitations**.

Urgent Care Services

All Primary Care Plan Physicians are on-call 24/7. When a situation is not an emergency but requires prompt attention for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, please call your Primary Care Plan Physician as instructed under *Making and Cancelling Appointments and Who to Contact* at the beginning of this section.

Bills for Emergency and Urgent Care Services

If you are balance billed by a Hospital, urgent care facility, physician or ancillary provider for Emergency Services or Urgent Care Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998

For more information on the payment or reimbursement of covered Services and how to file a claim, see *Post-Service Claims* in **Section 5: Filing Claims, Appeals and Grievances**.

Hospital Admissions

If you are admitted to a non-Plan Hospital, you, your Parent/Guardian, Financially Responsible Person or someone else must notify us within the later of forty-eight (48) hours of a Member's Hospital admission or on the first working day following the admission unless it was not reasonably possible to notify us within that time.

Getting Assistance from Our Advice Nurses

Our advice nurses are registered nurses (RNs) specially trained to help assess clinical problems and provide clinical advice. They can help solve a problem over the phone and instruct you on self-care at home, when appropriate. If the problem is more severe and you need an appointment, they will help you get one.

If you are not sure you are experiencing a medical emergency, or for Urgent Care Services for symptoms such as a sudden rash, high fever, severe vomiting, ear infection or sprain, you may call our advice nurses at 1-800-777-7904 or 711 (TTY). You may also call 1-800-677-1112 from anywhere in the United States, Canada, Puerto Rico or the Virgin Islands.

Getting a Second Opinion

You are welcome to receive a second medical opinion from a Plan Physician. We will assist you to arrange an appointment for a second opinion upon request.

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Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this EOC. Covered Services are subject to the terms and conditions of this EOC, including prior authorization requirements, the applicable Copayments, Coinsurance and/or Deductibles shown in the *Summary of Cost Shares* and the exclusions, limitations and reductions described in this EOC.

For more information about receiving care in other Kaiser Foundation Health Plan Service Area, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

Payment Toward Your Cost Share and When You May Be Billed

In most cases, you will be asked to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services, such as Primary Care treatment and laboratory tests, you may be required to pay separate Cost Shares for each of those Services. In some cases, your provider may not ask you to make a payment at the time you receive Services, and you may be billed for your Cost Share.

Keep in mind payments made by you, or on your behalf, toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay Cost Share amounts in addition to the amount you pay at check-in:

1. **You receive non-preventive Services during a preventive visit.** For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem, such as laboratory tests. You may be asked to pay your Cost Share for these additional non-preventive diagnostic Services.
2. **You receive diagnostic Services during a treatment visit.** For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services, such as laboratory tests. You may be asked to pay your Cost Share for these additional diagnostic Services.
3. **You receive treatment Services during a diagnostic visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services, such as an outpatient procedure. You may be asked to pay your Cost Share for these additional treatment Services.
4. **You receive non-preventive Services during a no-charge courtesy visit.** For example, you go in for a blood pressure check or meet and greet visit and the provider finds a problem with your health and performs diagnostic or treatment Services. You may be asked to pay your Cost Share for these additional diagnostic or treatment Services.
5. **You receive Services from a second provider during your visit.** For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay your Cost Share for the consultation with the specialist.

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Note: If your Plan is subject to a Deductible, any required Deductible amount must be met by the Member prior to our payment of non-preventive or diagnostic Services.

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SECTION 3: Benefits, Exclusions and Limitations

Your Benefits

The benefits described in this section are covered only when:

1. A Plan Physician determines that the Services are Medically Necessary;
2. The Services are provided, prescribed, authorized or directed by a Plan Physician; and
 - a. You receive the Services at a Plan Facility, Plan Provider or contracted Skilled Nursing Facility inside our Service Area (except when specifically noted otherwise within this Agreement); or
 - b. You agree to have Services delivered through a patient centered medical homes program for individuals with chronic conditions, serious illnesses or complex health care needs. This includes associated costs for coordination of care, such as:
 - i. Liaison services between the individual and the Health Care Provider, nurse coordinator and the care coordination team;
 - ii. Creation and supervision of a care plan;
 - iii. Education of the Member and their family regarding the Member's disease, treatment compliance and self-care techniques; and
 - iv. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.

You must receive all covered Services from Plan Providers inside our Service Area except for:

1. Emergency Services, as described in this section;
2. Urgent Care Services outside of our Service Area, as described in this section;
3. Continuity of Care for Members, as described in **Section 2: How to Get the Care You Need**;
4. Approved referrals, as described under **Getting a Referral in Section 2: How to Get the Care You Need**, including referrals for clinical trials as described in this section.

Note: Some benefits may require payment of a Copayment, Coinsurance or Deductible. Refer to the **Summary of Cost Shares** for the Cost Sharing requirements that apply to the covered Services contained within the **List of Benefits** in this section.

For authorized Services provided within our Service Area by a Plan Provider or a non-Plan Provider, you will not incur any additional cost sharing beyond that which is indicated in your **Summary of Cost Shares**.

If you are balance billed by a Hospital, urgent care center, physician or ancillary provider for covered Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998

For more information on the payment or reimbursement of covered Services and how to file a claim, see **Section 5: Filing Claims, Appeals and Grievances**.

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This Agreement does not pay for all health care services, even if they are Medically Necessary. Your right to benefits is limited to the covered Services contained within this contract. To view your benefits, see the *List of Benefits* in this section.

List of Benefits

The following benefits are covered by the Health Plan. Benefits are listed alphabetically for your convenience. Some benefits are subject to benefit-specific limitations and/or exclusions, which are listed, when applicable, directly below each benefit. A broader list of exclusions that apply to all benefits, regardless of whether they are Medically Necessary, is provided under *Exclusions* in this section.

Accidental Dental Injury Services
<p>We cover:</p> <ol style="list-style-type: none">1. Medically Necessary dental Services, including x-rays and extractions, as a result of accidental injury, regardless of the date of such injury, provided that for an injury occurring on or after your effective date of coverage you seek treatment within twelve (12) months after the injury.2. The cost of dental services and dental appliances only when provided by a Plan Provider to diagnose or treat an accidental injury to the teeth, jaw, mouth, or face;3. The repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face; and4. Oral and surgical correction of accidental injuries as indicated in <i>Section B – Adult Dental Plan</i> and <i>Section C – Pediatric Dental Plan</i>. <p>See the benefit-specific exclusions immediately below for additional information.</p>
<p>Benefit-Specific Exclusions:</p> <ol style="list-style-type: none">1. Services provided by non-Plan Providers except in an emergency;2. Treatment of natural teeth due to diseases;3. Treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 12 months after the injury;4. Damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered. <p>Refer to the <i>Adult Dental Plan</i> and <i>Pediatric Dental Plan</i> sections for additional dental coverage.</p>
Allergy Services
<p>We cover the following allergy Services:</p> <ol style="list-style-type: none">1. Testing2. Evaluation and treatment3. Injections and serum
Ambulance Services
<p>We cover ambulance Services provided by a licensed ambulance service only if:</p> <ol style="list-style-type: none">1. Your condition requires basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; or2. The ambulance transportation has been ordered by a Plan Provider. <p>A licensed ambulance is a state licensed vehicle that is designed, equipped, and used only to transport</p>

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the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest Hospital able to provide needed Services, provided during an encounter with an ambulance Service, as a result of a 911 call, or when ground or water transportation is not appropriate.

We cover medically appropriate non-emergent transportation Services when ordered by a Plan Provider.

We cover ambulance and medically appropriate non-emergent transportation Services only inside our Service Area, except as related to out of area Services covered under the “Emergency Services” provision in this section of the Agreement. Your Cost Share will apply to each encounter whether or not transport was required.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
2. Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

Anesthesia for Dental Services

We cover general anesthesia and associated Hospital or ambulatory facility Services, for Members who require such Services in order to safely and effectively receive dental care and who:

1. Are no more than 5 years of age; or
2. Are severely disabled; or
3. Have a medical condition (e.g., heart disease or hemophilia) and require admission to a Hospital or outpatient surgery facility and general anesthesia for dental treatment; or
4. Are 17 years of age or younger and are extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred, and for whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

See the benefit-specific exclusion immediately below for additional information.

Benefit-Specific Exclusion:

1. The dentist’s or specialist’s professional Services.

Blood, Blood Products and Their Administration

We cover blood, blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery, as well as cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider. The administration of blood and blood products are also covered.

In addition, we cover the purchase of blood products and blood infusion equipment, and the administration of the blood products and Services required for home treatment of routine bleeding

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episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Chemotherapy

We cover treatment of an illness by chemical or biological antineoplastic agents administered as a part of a doctor's visit, home care visit, or at an outpatient facility for treatment of an illness.

Cleft Lip, Cleft Palate or Ectodermal Dysplasia

We cover inpatient and outpatient Services when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Coverage includes orthodontics, oral surgery, otologic, audiological and speech/language treatment, and dental services and dental appliances furnished to a newborn child.

Clinical Trials

We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis. "Patient costs" mean the cost of a Medically Necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. "Patient costs" do not include:

1. The cost of an investigational drug or device, except as provided below for off-label use of an FDA approved drug or device;
2. The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
3. Costs associated with managing the research for the clinical trial.

We cover Services received in connection with a clinical trial if all of the following conditions are met:

1. The Services would be covered if they were not related to a clinical trial.
2. The Member is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition or disease (a condition or disease from which the likelihood of death is probable unless the course of the condition or disease is interrupted), as determined in one of the following ways:
 - a. A Plan Provider makes this determination.
 - b. The Subscriber or Member provides us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept the Member as a participant in the clinical trial, the Member must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where the Member lives.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition or disease and it meets one of the following requirements:
 - a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
 - b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
 - c. The study or investigation is approved or funded by at least one of the following:
 - i. The National Institutes of Health.
 - ii. The Centers for Disease Control and Prevention.
 - iii. The Agency for Health Care Research and Quality.

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- iv. The Centers for Medicare & Medicaid Services.
- v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
- vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- vii. The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
 - a) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
 - b) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, the same Cost Sharing applies that would apply if the Services were not related to a clinical trial.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

Diabetic Services

We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy, and Medically Necessary routine foot care, including treatment of corns, calluses, and care of toenails, when prescribed by a Plan Provider and purchased from a Plan Provider, for the treatment of:

1. Insulin-using diabetes;
2. Insulin-dependent diabetes;
3. Non-insulin using diabetes; or
4. Elevated blood glucose levels induced by pregnancy, including gestational diabetes.

Covered medical supplies and equipment include the following:

1. Insulin pumps;
2. Supplies needed for the treatment of corns, calluses, and care of toenails;
3. Home blood glucose monitors, lancets, blood glucose test strips, and hypodermic needles and syringes when purchased from a Plan Pharmacy or Plan Provider

Note: Insulin is not covered under this benefit. Refer to the *Outpatient Prescription Drug Benefit* section. Insulin pumps are not covered under this benefit. Refer to the “Durable Medical Equipment” benefit under the *Summary of Cost Shares*.

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the

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equipment or supply was prescribed by a Plan Provider and there is no equivalent preferred equipment or supply available, or an equivalent preferred equipment or supply has been ineffective in treating the disease or condition of the Member or has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a preferred vendor.

Dialysis Services

If the following criteria are met, we cover dialysis Services related to acute renal failure and chronic (end-stage) renal disease:

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis;
2. The facility (when not provided in the home) is certified by Medicare; and
3. A Plan Physician provides a written referral for care at the facility.

We cover the following renal dialysis Services:

1. Outpatient maintenance dialysis treatments in a Plan dialysis facility or doctor's office. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment.
2. Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
3. Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:

1. Training for self-dialysis including the instructions for a person who will assist you with self-dialysis.
2. Services of the Plan Provider who is conducting your self-dialysis training.
3. Retraining for use of new equipment for self-dialysis.

We cover home dialysis, which includes:

1. Hemodialysis;
2. Home intermittent peritoneal dialysis (IPD);
3. Home continuous cycling peritoneal dialysis (CCPD); and
4. Home continuous ambulatory peritoneal dialysis (CAPD).

Members requiring dialysis outside the service area for a limited time period may receive preplanned dialysis services in accordance to prior authorization requirements.

Drugs, Supplies and Supplements

We cover the following during a covered stay in a Plan Hospital, outpatient facility, or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office as part of a doctor's visit, or during home health care visits:

1. Oral, infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
2. Injectable devices;

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3. The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
4. Medical and surgical supplies including dressings, casts, hypodermic needles and syringes, or any other Medically Necessary supplies provided at the time of treatment; and
5. Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA) that are not considered part of routine preventive care

Note: Additional Services that require administration or observation by medical personnel are covered. See “Outpatient Prescription Drug Benefit,” for coverage of self-administered outpatient prescription drugs. “Preventive Health Care Services” for coverage of vaccines and immunizations that are part of routine preventive care; “Allergy Services” for coverage of allergy test and treatment materials; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices.

Coverage will not be denied:

1. For any drug approved by the United States Food and Drug Administration (FDA) for treatment of cancer because the drug has not been approved by FDA for treatment of the specific type of cancer for which it has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia.
2. For any drug prescribed to treat a covered indication if the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature.
3. For any drug approved by FDA for treatment of cancer pain because the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Drugs for which a prescription is not required by law.
2. Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
3. Drugs for the treatment of sexual dysfunction disorders.

Durable Medical Equipment

Durable Medical Equipment is defined as equipment that:

1. is intended for repeated use;
2. is primarily and customarily used to serve a medical purpose;
3. is generally not useful to a person in the absence of illness or injury; and
4. meets Health Plan criteria for Medical Necessity.

Refer to “Prosthetic Devices” for coverage of internal and external prosthetic and orthotic devices.

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Basic Durable Medical Equipment

We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

We cover the following types of equipment:

1. Hospital type beds;
2. Wheelchairs;
3. Traction equipment;
4. International Normalized Ratio (INR) home testing machines;
5. Walkers; and
6. Crutches.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. We will also cover the supplies and equipment needed for use of the equipment or device, such as a battery for a powered wheelchair. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it. **Note:** See “Diabetes Equipment, Supplies and Self-Management” for coverage of diabetes equipment and supplies.

Supplemental Durable Medical Equipment

We also cover oxygen concentrator, ventilators, negative pressure wound therapy devices, and the following Durable Medical Equipment for home use as separate benefits, and as indicated below.

Oxygen and Equipment. We cover oxygen and equipment for administration when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. A Plan Provider must certify the continued medical need for oxygen and equipment.

Positive Airway Pressure Equipment. We cover automatically-adjusting positive airway pressure (APAP), continuous positive airway pressure (CPAP), bi-level positive airway pressure (BIPAP) equipment and other oral devices for sleep treatment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. A Plan Provider must certify the continued medical need.

Apnea Monitors. We cover apnea monitors for infants, who are under age 3, for a period not to exceed 6 months.

Asthma Equipment. We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Pharmacy or Plan Provider:

1. Spacers
2. Peak-flow meters
3. Nebulizers

Bilirubin Lights. We cover bilirubin lights for infants who are under age 3, for a period not to exceed 6 months.

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See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Comfort, convenience, or luxury equipment or features
2. Exercise or hygiene equipment
3. Non-medical items such as sauna baths or elevators
4. Modifications to your home or car
5. Electronic monitors of the heart or lungs, except infant apnea monitors and oximetry monitors for patients on home ventilation.
6. Prosthetic and orthotic devices, except as covered under “Prosthetic Devices”

Early Intervention Services

We cover Medically Necessary early intervention Services for Dependents, from birth to age 3, who are certified by the Department of Behavioral Health and Developmental Services (“the Department”) as eligible for Services under Part C of the Individuals with Disabilities Education Act. These Services consist of:

1. Speech and language therapy;
2. Occupational therapy;
3. Physical therapy; and
4. Assistive technology Services and devices.

Early intervention Services for the population certified by the Department are those Services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include Services which enhance functional ability without effecting a cure. Benefits for Services listed shall not be limited by the exclusion of Services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy listed in *Therapy; Habilitative and Rehabilitative Services* will not apply if you get that care as part of the early intervention benefit.

Emergency Services

As described below, you are covered for medical emergencies anywhere in the world.

Emergency Services are health care Services that are provided by a Plan or non-Plan Provider after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient’s health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or,
4. In the case of a pregnant woman, serious jeopardy to the health of the mother and/or fetus.

If you think you are experiencing a medical emergency, you should call 911 immediately. If you are not sure whether you are experiencing a medical emergency, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify Health Plan as soon as possible, not to exceed forty-eight (48) hours or the end of the first business day, whichever is later, after you receive care in a Hospital emergency room to ensure coverage. If you are

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incapacitated and unable to notify us within 48 hours, you or your representative must notify us as soon as reasonably possible. Coverage depends on our determination of the situation in which care was provided, and not solely on the advice of the non-Plan Provider.

If an emergency room visit is made for a condition that is not a true emergency, then assessment and stabilization are covered.

We cover Emergency Services as follows:

Inside our Service Area

We cover emergency room professional services, including diagnostic x-ray, laboratory services, medical supplies and advanced diagnostic imaging such as magnetic resonance imaging (MRI) and computed tomography (CT) scans, for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan Provider. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your *Summary of Cost Shares*. After Emergency Services have been received inside the Service Area, continuing or follow-up treatment is available from your primary care Plan Physician. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or primary care Plan Physician's office.

Outside our Service Area

If you are injured or become ill while temporarily outside the Service Area, but within the United States, we will cover charges for Emergency Services as defined in this section. We cover emergency room professional services, including diagnostic x-ray, laboratory services, medical supplies, and advanced diagnostic imaging such as magnetic resonance imaging (MRI) and computed tomography (CT) scans. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your *Summary of Cost Shares*. We will cover Services received outside of the Service Area until you can, without medically harmful consequences, be transported to a Plan Hospital or primary care Plan Physician's office.

Outside the United States

If you are injured or become ill while temporarily outside the United States, we will cover charges for Emergency Services as defined in this section; subject to the same Cost Shares that would apply if the Service was provided inside our Service Area. You will not incur any additional cost sharing for Emergency Services beyond that which is indicated in your *Summary of Cost Shares*.

See the benefit-specific limitations below for additional information.

Bills for Emergency Services

If you are balance billed by a Hospital, physician or ancillary provider for Emergency Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
PO Box 371860
Denver, CO 80237-9998

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For more information on the payment or reimbursement of covered Services and how to file a claim, see *Section 5: Filing Claims, Appeals and Grievances*.

Benefit-Specific Limitations:

1. Notification

If you receive care at a Hospital emergency room and/or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, not later than forty-eight (48) hours of any emergency room visit or admission or on the first working day following the emergency room visit or admission, whichever is later, unless it was not reasonably possible to notify us. If admitted to a Hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. Once your emergency condition has been stabilized, all continuing and follow-up treatment must be authorized by us. If you do not notify us and obtain authorization for a continued Hospital stay once your condition has stabilized, we will not cover the inpatient hospital charges you incur after transfer would have been possible.

2. Continuing or Follow-Up Treatment

We do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the non-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

3. Hospital Observation

Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit Copayment, if applicable, will not be waived.

Family Planning Services

We cover the following:

1. Women's preventive services, including:
 - a. Patient education and contraceptive method counseling for all women of reproductive capacity;
 - b. Coverage for FDA-approved contraceptive devices, hormonal contraceptive methods, the insertion or removal of contraceptive devices, including any Medically Necessary examination associated with the use of contraceptive drugs and devices; and
 - c. Female sterilization, including anesthesia during surgery.
2. Other family planning counseling, including pre-abortion and post-abortion counseling.
3. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider and are covered under this benefit. Contraceptive drugs and diaphragms are covered under the **"Outpatient Prescription Drug Benefit."**
4. Vasectomies.
5. Voluntary termination of pregnancy.

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Hearing Services

Hearing Exams

We cover hearing tests to determine the need for hearing correction, when ordered by a Plan Provider. See “Preventive Health Care Services” for coverage of newborn hearing screenings.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Tests to determine an appropriate hearing aid.
2. Hearing aids or tests to determine their efficacy.

Home Health Services

We cover the following home health Services only within our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home:

1. Skilled nursing Services;
2. Home health aide Services;
3. Medical social Services;
4. Training of you, your family member, or your caregiver;
5. Medical supplies; and
6. Remote patient monitoring.

Home health Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel, are directed by a Plan Provider, and are provided intermittently. They include visits by a licensed health care professional, including private duty nurses (Registered Nurse (RN) and Licensed Practical Nurse (LPN), therapists, or home health aides who work under the supervision or direction of a registered nurse or medical doctor.

The following types of Services are covered as part of home health Services only as described under the following headings in this section of the Agreement:

1. Blood, Blood Products and Their Administration
2. Diagnostic Services
3. Dialysis Services
4. Drugs, Supplies and Supplements
5. Durable Medical Equipment
6. Ostomy and Urological Supplies
7. Therapy and Rehabilitation Services
8. Maternity Services
9. Nutrition Counseling

Home Health Visits Following Mastectomy or Removal of Testicle

Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as those who receive less than forty-eight (48) hours of inpatient hospitalization following the surgery, are entitled to the following: one home visit scheduled to occur within twenty-four (24) hours following his or her discharge; and one additional home visit, when prescribed by the patient’s attending physician.

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See the benefit-specific limitations and exclusions immediately below for additional information.

<p>Benefit-Specific Limitations:</p> <ol style="list-style-type: none"> 1. Private-duty nursing is limited to sixteen (16) hours per Calendar Year. 	<p>Benefit-Specific Exclusions:</p> <ol style="list-style-type: none"> 1. Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Coordination of Benefits” section). 2. Routine administration of oral medications, eye drops, ointments. 3. General maintenance care of colostomy, ileostomy, and ureterostomy. 4. Medical supplies or dressings applied by a Member or family caregiver. 5. Corrective appliances, artificial aids, and orthopedic devices. 6. Homemaker Services. 7. Services that a Plan Provider determines may be provided in a Plan Facility and we provide or offer to provide that care in one of these facilities. 8. Transportation and delivery service costs of Durable Medical Equipment, medications and drugs, medical supplies, and supplements to the home.
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Hospice Care Services

Hospice Care Services are for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice Services through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care Services in the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

We cover Hospice Care Services within our Service Area and only when provided by a Plan Provider. Hospice Care Services include the following:

1. Nursing care;
2. Physical, occupational, speech, and respiratory therapy;
3. Medical social Services;
4. Home health aide Services;
5. Homemaker Services;
6. Medical supplies and appliances;
7. Palliative drugs in accord with our drug formulary guidelines;
8. Physician care;
9. Nutritional counseling;
10. General hospice inpatient Services for acute symptom management including pain management;

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11. Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to four (4) times in any Calendar Year;
12. Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family Members, for a period of one year after the Member's death;
13. Services of hospice volunteers; and
14. Benefits for covered services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in hospice. These additional covered services will be covered under other parts of this Plan.

Definitions:

1. **Family Member** means a relative by blood, marriage, domestic partnership or adoption who lives with or regularly participates in the care of the terminally ill Member.
2. **Hospice Care** means a coordinated, inter-disciplinary program of hospice Services for meeting the special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.
3. **Respite Care** means temporary care provided to the terminally ill Member to relieve the Member's Caregiver from the daily care of the Member.
4. **Caregiver** means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Services.

Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by an acute care general hospital in our Service Area:

1. Injury and Illness
2. Room and board (includes bed, meals, and special diets), including private room when deemed Medically Necessary;
3. Specialized care and critical care units;
4. General and special nursing Services;
5. Operating and recovery room;
6. Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
7. Anesthesia, including services of an anesthesiologist;
8. Medical supplies;
9. Chemotherapy and radiation therapy;
10. Respiratory therapy; and
11. Medical social Services and discharge planning.

Additional inpatient Services are covered only as specifically described under the appropriate heading in this "Benefits" section.

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Minimum Hospital Stay

We cover inpatient hospitalization Services for you and your newborn child for a minimum stay of at least forty-eight (48) hours following an uncomplicated vaginal delivery; and at least ninety-six (96) hours following an uncomplicated cesarean section. We also cover postpartum home health visits upon release.

In consultation with your physician, you may request a shorter length of stay. In such cases, we will cover one home health visit scheduled to occur within twenty-four (24) hours after discharge, and an additional home visit if prescribed by the attending provider.

Up to four (4) days of additional hospitalization for the newborn is covered if the enrolled mother is required to remain hospitalized after childbirth for medical reasons.

We cover a minimum hospital stay of no less than forty-eight (48) hours following a radical or modified radical mastectomy and no less than twenty-four (24) hours following a total or partial mastectomy with lymph node dissection.

We cover a minimum hospital stay of no less than twenty-three (23) hours for a laparoscopy-assisted vaginal hysterectomy and forty-eight (48) hours for a vaginal hysterectomy.

Infertility Diagnostic Services

Covered infertility services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Infertility benefit also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis and hormone deficiency).

Fertility treatments such as artificial insemination and in vitro fertilization (IVF) are not a covered service. Nor are the medications for the treatment of infertility a covered benefit.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Artificial insemination, in vitro fertilization (IVF), ovum transplants and gamete intrafallopian tube transfer (GIFT), zygote intrafallopian transfer (ZIFT), or cryogenic or other preservation techniques used in these or similar procedure.
2. Infertility drugs used in assisted reproductive technology (ART) procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
3. Any services or supplies provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
4. Services to reverse voluntary, surgically induced infertility; or fallopian scar revision surgery.

Infusion Therapy Services

We cover Services for drug infusion therapy and infusion therapy, which is treatment by placing therapeutic agents into the vein, including therapeutic nuclear medicine, and parenteral administration of medication and nutrients. Infusion therapy includes nursing, durable medical equipment and drug services that are delivered and administered to you through an I.V. by a Plan Provider as part of a doctor's visit, home care visit or at an outpatient facility. Infusion services also include Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care, blood products, blood infusion equipment

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and chemotherapy. Medically Necessary injectables that are not self-administered are covered. The cost share amount will apply based on the place and type of service provided.

Maternity Services

Health plan covers pre-natal and post-natal services, which includes pregnancy testing, routine and non-routine office visits, telemedicine visits, x-ray, lab and specialty tests. Health Plan covers birthing classes and breastfeeding support, supplies, and counseling from trained providers during pregnancy and/or in the postpartum period. Routine Prenatal Care hospitalization is covered with a minimum stay of forty-eight (48) hours.

Pregnancy Testing

We cover tests to determine if you are pregnant.

Prenatal and Newborn Care

If you (or your covered Dependent) become pregnant, Health Plan provides coverage for maternity care, maternity-related checkups, and delivery of the baby in the hospital.

We cover the following:

1. Use of the delivery room and care for normal deliveries;
2. Home *setting* covered with nurse midwives;
3. Anesthesia services to provide partial or complete loss of sensation before delivery;
4. Hospital services for routine nursery care for the newborn during the mother's normal hospital *stay*;
5. Prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
6. Screenings for pregnant women for anemia, urinary tract or other infections;
7. Folic acid supplements;
8. Behavioral assessments and measurements;
9. Screenings for blood pressure;
10. Expanded tobacco intervention and counseling for pregnant users;
11. Initial examination of a newborn and circumcision of a covered male dependent;
12. Services for interruption of pregnancy, limited to the following circumstances:
 - a. When the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or
 - b. When the pregnancy is the result of an alleged act of rape or incest; and
13. Fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

All physician services and professional fees for your routine maternity care, including prenatal and postnatal care Services, will be covered with a single Cost Share. Services that are preventive care will be covered with no Cost Share. Additional Cost Shares may apply to professional fees for any non-routine Services you receive. Your inpatient fees are the same as for any other inpatient stay.

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Medical Foods

We cover special medical formulas which are the primary source of nutrition for members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies.

Coverage is provided if the medical foods and low protein food products are prescribed as Medically Necessary for therapeutic treatment and required to maintain adequate nutritional status and are administered under the direction of a Plan Provider.

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered enterally (i.e. by tube directly into the stomach or small intestines) under the direction of a Plan Provider.

Low protein modified foods are food products that are:

1. Specially formulated to have less than one (1) gram of protein per serving; and
2. Intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

We do not cover nutritional counseling and related services, except when received as part of a covered wellness service visit or screening, diabetes education, or for hospice with respect to person's care.

Mental Health Services and Substance Use Disorder

Mental Health Services means planned individualized interventions intended to reduce or improve mental illness or the effects of mental illness through care, treatment, counseling, rehabilitation, medical or psychiatric care, or other supports provided to individuals with mental illness.

Substance Use Disorder means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial, or psycho-social.

We cover inpatient and outpatient Mental Health Services, which includes diagnostic evaluation, partial day Mental Health Services and Substance Use Disorder services, and intensive outpatient programs for treatment of alcohol or drug dependence including opioid treatment Services. We cover individualized and intensive treatment in a residential treatment facility which includes observation and assessment by a psychiatrist at least weekly and rehabilitation, therapy, education and recreational or social activities.

Inpatient Service

While you are an inpatient in a hospital, Plan Facility or program, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Physician including:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Convulsive therapy
5. Electroconvulsive therapy
6. Drug therapy
7. Education
8. Treatment for psychiatric conditions

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9. Psychiatric nursing Services
10. Appropriate Hospital Services
11. Structured program of treatment and rehabilitation, including twenty-four (24) hour-a-day nursing care
12. Counseling with family members to assist with patient's diagnosis and treatment
13. Medical Services for detoxification

Residential Treatment

Residential treatment means specialized twenty-four (24)-hour treatment in a licensed Residential Treatment center or intermediate care facility. It offers individualized and intensive treatment and includes:

1. Observation and assessment by a psychiatrist weekly or more often; and
2. Rehabilitation, therapy, education, and recreational or social activities.

You can receive Covered Services from the following Plan Providers:

1. Psychiatrist
2. Psychologist
3. Neuropsychologist
4. Licensed clinical social worker (L.C.S.W)
5. Mental health clinical nurse specialist
6. Licensed marriage and family therapist (L.M.F.T)
7. Licensed professional counselor (L.P.C)
8. Any agency licensed by the state to provide these services

Note: Inpatient Services for the treatment of disorders such as substance use disorder and eating disorders cannot be merely custodial, residential, or domiciliary in nature and must be provided in a hospital or residential treatment facility that is licensed to provide a continuous, structured program of drug or alcohol treatment and rehabilitation including twenty-four (24)-hour-a-day nursing care.

We cover partial hospitalization in a Plan Facility. Partial hospitalization is defined as a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Outpatient Service

In an outpatient setting, we cover office visits, outpatient facility and physician charges, and all necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a Plan Physician including, but not limited to:

1. Evaluation and diagnosis
2. Crisis intervention
3. Individual psychotherapy

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4. Group psychotherapy
5. Psychological and neuropsychological testing
6. Medical treatment for withdrawal symptoms
7. Treatment for psychiatric conditions
8. Visits for medication checks

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Services for Members who, in the opinion of the Plan Provider, are seeking services and supplies for non-therapeutic purposes
2. Applied Behavior Analysis (ABA)
3. Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate.
4. Evaluations that are primarily for legal or administrative purposes and are not Medically Necessary.

Morbid Obesity Services

We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or another surgical method that is recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and is consistent with criteria approved by the National Institutes of Health.

Morbid obesity is defined as:

1. A weight that is at least one hundred (100) pounds over or twice the ideal weight for a patient's frame, age, height and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index that is:
 - a. equal to or greater than forty (40) kilograms per meter squared; or
 - b. equal to or greater than thirty-five (35) kilograms per meter squared with a co-morbid or co-existing medical condition, such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes.

Body Mass index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Oral Surgery Services

We cover diagnosis, oral surgery, and related medical care for:

1. Surgical treatment of tumors in the oral cavity, where a biopsy is needed for evaluation of pathology;
2. Maxillary or mandibular frenectomy when not related to a dental procedure;
3. Alveolectomy when related to tooth extraction;
4. Orthognathic surgery, including inpatient and outpatient surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome and Craniomandibular joint disorders, that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part;
5. Removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic Services;

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6. Anesthesia to prepare mouth for medical treatments, such as radiation therapy to treat cancer and prepare for transplants;
7. Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
8. The treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia (see also “Cleft Lip, Cleft Palate, or Ectodermal Dysplasia” in this Section);
9. Treatment of non-dental lesions, such as removal of tumors and biopsies;
10. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses and;
11. Oral and/or surgical correction of accidental injuries as described in “Accidental Dental Injury Services”.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures
2. Orthodontic care, except as required in the treatment of cleft lip, cleft palate, or ectodermal dysplasia

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment:

1. Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics and gynecology Services (refer to “Preventive Health Care Services” for coverage of preventive care Services);
2. Specialty care visits (refer to “Standing Referrals to Specialists” in the “How to Obtain Services” section for information about referrals to Plan specialists);
3. Walk-in Services available from any Plan Facility. These Services are available 24 hours a day in certain Plan Medical Centers, including Services provided by nurse practitioners and physician assistants. Call Member Services for location and hours of operation of all of our Plan Facilities.
4. Consultations and immunizations for foreign travel;
5. Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
 - a. Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided:
 - i. To persons age 50 and over;
 - ii. To persons age 40 and over who are at high risk;
 - iii. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; and
 - iv. When used for staging in determining the need for a bone scan in patients with prostate cancer;
6. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiological imaging, for

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persons, who are at high risk of cancer, in accordance with the most recently published guidelines of the American Cancer Society. Your initial screening colonoscopy will be preventive.

7. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means:
 - a. An estrogen deficient individual at clinical risk for osteoporosis;
 - b. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
 - c. An individual receiving long-term gluco-corticoid (steroid) therapy;
 - d. An individual with primary hyper-parathyroidism; or
 - e. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Note: As described here, diagnostic testing is not preventive care and may include an office visit, outpatient surgery, diagnostic imaging, or x-ray and lab. The applicable Copayment or Coinsurance, if any, will apply based on the place and type of Service provided.

(Refer to “Preventive Health Care Services” for coverage of preventive care tests and screening Services);

8. Outpatient surgery received at an outpatient or ambulatory surgery facility, or doctor’s office;
9. Physician/Surgical Supplies;
10. Anesthesia, including Services of an anesthesiologist;
11. Chemotherapy and radiation therapy;
12. Respiratory therapy;
13. Sleep treatment;
14. Medical social Services;
15. Equipment and medical and surgical supplies, including hypodermic needles, syringes, surgical dressings, and splints;
16. House calls when care can best be provided in your home as determined by a Plan Provider;
17. After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
18. Equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under the law.

Additional outpatient Services are covered, but only as specifically described in this “Benefits” section, and subject to all the limits and exclusions for that Service.

Preventive Health Care Services

In addition to any other preventive benefits described in the Agreement, Health Plan shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles, Copayment amounts, or Coinsurance amounts to any Member receiving any of the following benefits for services from Plan Providers for infants, children, adolescents and adults:

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1. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009. Examples include screenings for BRCA genetic testing, Type 2 Diabetes, cholesterol, cervical cancer, counseling for breast cancer genetic testing or breast cancer chemoprevention. You may see a list of the most recent services described in this provision at: www.healthcare.gov;
2. Immunizations, including flu shots and their administration, for children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

The Health Plan also covers medically appropriate preventive health care Services based on your age, sex, and other factors as determined by your primary care Plan Physician in accordance with national preventive health care standards.

These Services include:

1. Routine physical examinations and health screening tests appropriate to your age and sex;
2. Well-woman examinations;
3. Well child care examinations, including child health supervision services for the periodic review of a child's physical and emotional status and immunizations offered at the following age intervals: birth, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, five years, and six years;
4. Sterilization services and services to reverse a non-elective sterilization resulting from an illness or injury. Male and female sterilizations must be covered;
5. Hemoglobinopathies screening for newborn children;
6. Gonorrhea prophylactic medication;
7. Hypothyroidism screening;
8. PKU screening;
9. Rh incompatibility screening;
10. Abdominal aortic aneurysm screening;
11. Depression screening;
12. Lung cancer screening;
13. Colorectal screening;
14. Routine and Medically Necessary immunizations (travel immunizations are not preventive and are covered under Outpatient Services in this section) for children and adults in accordance with

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- Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
15. Annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;
 16. High-risk human papillomavirus DNA testing every three years for women age 30 years and over whether or not they have normal Pap test results;
 17. Screening for gestational (pregnancy-related) diabetes in pregnant women between 24-28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;
 18. Comprehensive lactation (breastfeeding) education and counseling, by trained clinicians during pregnancy and/or in the postpartum period in connection with each birth;
 19. Breastfeeding support, equipment and supplies, including one (1) breast pump per pregnancy, as required under the current guidelines for infants and women by the Health Resources and Services Administration;
 20. Annual screening and counseling for sexually transmitted infections for all sexually active women;
 21. Annual screening and counseling for human immune-deficiency virus (HIV) infection for all sexually active women;
 22. Annual screening and counseling for interpersonal and domestic violence;
 23. Patient education and contraceptive counseling for all women with reproductive capacity;
 24. All prescribed FDA-approved contraceptive methods, including implanted contraceptive devices, hormonal contraceptive methods, barrier contraceptive methods, and female sterilization surgeries. We cover all 18 FDA-approved contraceptive methods and sterilization treatments for women, including drugs, injectables, patches, rings and devices such as diaphragms, IUDs, and implants. This includes all related counseling. Note that contraceptive methods that do not require clinician administration such as birth control pills will not be covered if you have outpatient drug coverage separate from your Health Plan coverage through another prescription drug provider;
 25. Low dose screening mammograms to determine the presence of breast cancer are covered as follows: (i) one mammogram for persons age 35 through 39; (ii) one mammogram biennially for persons age 40 through 49; and (iii) one mammogram annually for person 50 and over;
 26. Medical History assessments;
 27. Behavioral and oral health risk assessments;
 28. Bone mass index measurement to determine risk for osteoporosis;
 29. Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to persons age 50 and over and for persons age 40 and over who are at high risk;
 30. Colorectal cancer screening in accordance with American Cancer Society guidelines including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
 31. Cholesterol test (lipid profile);
 32. Screenings for high blood pressure;
 33. Diabetes screening (fasting blood glucose test);

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34. Screenings for autism (18 and 24 months), blood pressure, cervical dysplasia, depression, development, dyslipidemia, hematocrit or hemoglobin, lead, tuberculin, and vision;
35. Aspirin in the prevention of cardiovascular disease;
36. Sexually Transmitted Disease (STD) and Sexually Transmitted Infection (STI) testing (including chlamydia, gonorrhea, and syphilis) and counseling;
37. Annual chlamydia screening for
 - a. Women under the age of 20, if they are sexually active; and
 - b. Women 20 years of age or older, and men of any age, who have multiple risk factors, which include:
 - i. A prior history of sexually transmitted diseases;
 - ii. New or multiple sex partners;
 - iii. Inconsistent use of barrier contraceptives; or
 - iv. Cervical ectopy.
38. HIV testing;
39. Hepatitis B and C screening;
40. Syphilis screening;
41. TB test;
42. Alcohol and drugs screening, assessments, and counseling;
43. Nutritional counseling when received as part of a covered wellness service screening, diabetes education, and for hospice with respect to person's care and death;
44. Body mass index (BMI) measurements;
45. Obesity screening and counseling;
46. Nicotine patches and gum for smoking and tobacco cessation;
47. Smoking, screening, and tobacco cessation counseling;
48. Supplements for fluoride chemoprevention and iron;
49. Newborn hearing screenings; and
50. Associated preventive care radiological and lab tests not listed above.

Note: Refer to “Outpatient Care” for coverage of non-preventive diagnostic tests.

See the benefit-specific limitations immediately below for additional information.

Benefit-Specific Limitations:

While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. The applicable Copayment or Coinsurance will apply:

1. Monitoring a chronic disease;
2. Follow-up Services after you have been diagnosed with a disease;
3. Diagnosis of a specific disease when you show signs or have higher than average risk for the disease;
4. Services when you show signs or symptoms of a specific disease or disease process;
5. Non-routine gynecological visits will be charged at the specialty Copayment;
6. Lab, imaging, and other ancillary Services not included in routine prenatal care.
7. Over-the-counter contraceptive pills, supplies, and devices.
8. Personal and convenience supplies associated with breastfeeding equipment such as pads, bottles, and carrier cases.

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9. Replacement or upgrades for breastfeeding equipment that is not rented Durable Medical Equipment.
10. Prescription contraceptives that do not require clinical administration for certain group health plans that provide outpatient prescription drug coverage that includes FDA-approved contraception that is separate from Health Plan coverage and furnished through another prescription drug provider.

Prosthetic and Orthotic Devices

We cover the following:

1. Artificial limbs, eyes and components;
2. Cochlear implants;
3. Orthopedic braces;
4. Leg braces, including attached or built-up shoes attached to a leg brace;
5. Orthotics, other than foot orthotics, including the cost of fitting, adjustment, and repair;
6. Molded, therapeutic shoes and inserts for diabetics with peripheral vascular disease;
7. Arm, back, and neck braces;
8. Head halters;
9. Catheters and related supplies;
10. Splints; and
11. Composite facial prosthesis.

Prosthetics are covered if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Orthotic devices such as leg, arm, back and neck braces and boots that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body are covered when prescribed by a Plan Provider. This coverage also includes molded therapeutic shoes and inserts for diabetics with peripheral vascular disease.

Internally Implanted Devices

We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants (see “Reconstructive Surgery” following mastectomy” below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

Artificial Limbs

We cover Medically Necessary prosthetic devices to replace, in whole or in part, a limb; and, their repair, fitting, replacement, and components.

As used in this provision:

“Limb” means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

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“Component” means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Colostomy, Ostomy and Urological Supplies

We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for Medical Necessity. We cover colostomy and other ostomy supplies directly related to ostomy care.

Breast Prosthesis

We cover breast prostheses and mastectomy bras, needed after a Medically Necessary mastectomy. Coverage includes custom-made internal and external breast prostheses, regardless of when the mastectomy was performed. Coverage for breast prostheses for the non-diseased breast is also provided to achieve symmetry.

Wigs

We cover wigs for a Member whose hair loss was the result of chemotherapy or radiation treatment for cancer.

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit Specific Limitations:

1. Coverage for mastectomy bras is limited to a maximum of two (2) per Calendar Year.
2. Coverage for wigs are limited to one (1) per Calendar Year.

Benefit Specific Exclusions:

1. Internally implanted breast prostheses for cosmetic purposes.
2. External Prostheses, except as provided in this Section.
3. Repair or replacement of prosthetic devices due to loss, neglect, misuse, or abuse.
4. Hair prosthesis, except as specified above.
5. Artificial limbs designed primarily for an athletic purpose.
6. Microprocessor and robotic controlled external prosthetics and orthotics not covered under the Medicare Coverage Database.
7. Multifocal intraocular lens implants.

Pulmonary Rehabilitation

Includes outpatient short-term respiratory care to restore your health after an illness or injury.

Reconstructive Surgery

We cover reconstructive surgery to:

1. Correct significant disfigurement resulting from an illness, injury, previous treatment, or Medically Necessary surgery;
2. Correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function; and

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<p>3. Treat congenital hemangioma known as port wine stains on the face.</p> <p>Following or at the same time of a mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.</p> <p>We also cover the following inpatient and outpatient Services:</p> <ol style="list-style-type: none"> 1. Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children; 2. Surgeries and procedures to correct significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery; 3. Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine; 4. Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, and laparoscopy; 5. Treatment of fractures and dislocation, including splints; and 6. Pre-operative and post-operative care. <p>See the benefit-specific exclusions immediately below for additional information.</p>	
<p>Benefit-Specific Exclusions: Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or will not result in significant improvement in physical function. Examples of excluded cosmetic dermatology services are:</p> <ol style="list-style-type: none"> 1. Removal of moles or other benign skin growths for appearance only 2. Chemical peels 3. Pierced earlobe repairs, except for the repair of an acute bleeding laceration 	
<p>Routine Foot Care</p>	
<p>Coverage is provided for Medically Necessary routine foot care for patients with diabetes or other vascular disease.</p> <p>See the benefit-specific limitation and exclusion immediately below for additional information.</p>	
<p>Benefit-Specific Limitation: Coverage is limited to Medically Necessary treatment of patients with diabetes or other vascular disease.</p>	<p>Benefit-Specific Exclusions: Routine foot care is not provided to Members who do not meet the requirements of the limitations of this benefit.</p>
<p>Skilled Nursing Facility Care</p>	
<p>We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required.</p>	

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<p>We cover the following Services:</p> <ol style="list-style-type: none"> 1. Room and board; 2. Physician and nursing care; 3. Medical social Services; 4. Drugs, biologicals, and medical supplies; 5. Respiratory therapy; 6. Skilled convalescent care; and 7. Rehabilitative therapy. <p>See the benefit-specific limitations and exclusions immediately below for additional information.</p>	
<p>Benefit Specific Limitations: We cover up to one hundred (100) days of skilled nursing inpatient Services per stay.</p>	<p>Benefit Specific Exclusions:</p> <ol style="list-style-type: none"> 1. Custodial care (see description in the “Exclusions, Limitations, and Coordination of Benefits” Section). 2. Domiciliary care. 3. See “Therapy; Habilitative and Rehabilitative Services” for coverage of therapy during an inpatient stay.
<p>Telemedicine Services</p>	
<p>We cover interactive telemedicine visits with a Plan Provider. Telemedicine is the real-time, two-way transfer of medical data and information. Telemedicine services include the interactive use of audio, video, or other electronic media, such as internet communication between Plan Provider and patient by webcam, chat or voice, used for the purpose of diagnosis, consultation, treatment or providing remote patient monitoring Services as it pertains to the delivery of covered health care services. Such webcam, chat and voice medical visits are covered in place of an office visit. Equipment utilized for interactive telemedicine should be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services.</p> <p>See the benefit-specific exclusions immediately below for additional information.</p>	
<p>Benefit-Specific Exclusions: Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.</p>	
<p>Therapy; Habilitative and Rehabilitative Services</p>	
<p>If, in the judgment of a Plan Physician, significant improvement is achievable within a ninety (90)-day period, we cover physical, occupational and speech therapy. Habilitative Services include coverage for health care Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age.</p> <p>These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings.</p> <p>Rehabilitative Services includes coverage for health care Services, devices, and therapies to restore and in some cases, maintain capabilities lost due to disease, illness, injury, or in the case of speech therapy, loss additionally due to congenital anomaly or prior medical treatment. To be a covered service,</p>	

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rehabilitative services must involve goals you can reach in a reasonable period of time. Benefits will end once treatment is no longer Medically Necessary and you stop progressing toward those goals.

We provide coverage for the following habilitative and rehabilitative Services, including professional Services, when Medically Necessary and provided by a licensed or certified therapist.

Cardiac Rehabilitation Services

We cover medical evaluation, training, supervised exercise, and psychosocial support Services following a cardiac event (heart problem) when approved by Health Plan.

Cardiac rehabilitation Services must be provided or coordinated by a facility approved by Health Plan, and that offers the process of diagnosing, restoring, maintaining, teaching, or improving physiological, psychological, social and vocational capabilities of patients with heart disease.

Chiropractic/Osteopathic/Manipulation Therapy

We cover therapy to treat problems of the bones, joints, and the back. We cover these therapies for a maximum of thirty (30) visits combined per Calendar Year. This thirty (30)-visit maximum applies separately for rehabilitative therapy and habilitative therapy.

Multidisciplinary Rehabilitation

We cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility. Coverage is limited to a maximum of thirty (30) visits per Calendar Year. This limit does not apply to inpatient or home health Services.

Multidisciplinary rehabilitation Service programs are inpatient or outpatient day programs that incorporate more than one therapy at a time in the rehabilitation treatment.

Physical, Occupational, and Speech Therapy

The visit limits listed below for physical, occupational and speech therapy apply separately to habilitative and rehabilitative Services. You receive a maximum of thirty (30) visits each per Calendar Year for physical therapy, occupational therapy and speech therapy for both rehabilitative therapy and habilitative therapy. The limits do not apply to therapy provided while you are an inpatient in a hospital or to early intervention services, home health Services, and hospice care.

Early intervention services for the population certified by the Department are those services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention benefit.

Physical Therapy

We cover inpatient and outpatient physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Physical therapy services include heat, hydrotherapy, physical agents, bio-mechanical and neuro-physiological principles and devices. Your coverage includes benefits for physical therapy to treat lymphedema. Coverage for outpatient physical therapy is limited to a maximum of thirty (30) visits per Calendar Year.

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Occupational Therapy

We cover inpatient and outpatient occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing and job-related activities. Coverage for occupational therapy is limited to a maximum of thirty (30) visits per Calendar Year.

Speech Therapy

We cover inpatient and outpatient speech therapy. Speech therapy is the identification, assessment, and treatment for the correction of a speech impairment, language, or swallowing disorders in children and adults. Speech therapy includes Services necessary to improve or teach speech, language, or swallowing skills, which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment and will treat communication or swallowing difficulties to correct a speech impairment. Coverage for outpatient speech therapy is limited to a maximum of thirty (30) visits per Calendar Year.

Radiation Therapy

We cover radiation therapy. Radiation therapy includes the treatment of an illness by X-ray, radium, cobalt, radioactive isotopes, photon or high energy particle sources, teletherapy, brachytherapy, and intraoperative radiation. Coverage includes the rental or cost of radioactive materials, needed supplies, administration, treatment planning and certain other covered Services. We also cover the dental Services needed to prepare the mouth for radiation therapy.

Respiratory Services

We cover respiratory therapy, which is the introduction of dry or moist gases into the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and spirometers; broncho-pulmonary drainage and breathing exercises to treat illness or injury.

See the benefit-specific limitations and exclusions immediately below for additional information.

Benefit-Specific Limitations:

1. The limitations listed for physical, occupational and speech therapy also apply to those Services when provided within a multidisciplinary program.
2. Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

Benefit-Specific Exclusions:

1. Long-term rehabilitation therapy except as provided for cardiac rehabilitation Services.
2. Cardiac Rehabilitation Services will not be provided for home programs (other than home health care Services), ongoing conditioning and maintenance care.

Transplant Services

We cover any Medically Necessary stem cell, bone marrow, organ and tissue transplants, transfusions, and infusions, including autologous bone marrow transplants for breast cancer, if the following criteria are met:

1. You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant;

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2. The facility is certified by Medicare; and
3. A Plan Provider provides a written referral for care at the facility.

Coverage also includes necessary acquisition procedures, mobilization, and harvest and storage. It also includes Medically Necessary preparatory myeloablative therapy or reduced intensity preparative chemotherapy, radiation therapy or a combination of these therapies.

After the referral to a transplant facility, the following applies:

1. Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
2. If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
3. Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.
4. When a human organ or tissue transplant is provided from a living donor to a member, both the recipient and the donor may receive the benefits of the Health Plan. We cover reasonable medical, hospital, transportation, and lodging. We cover reasonable medical and hospital expenses as long as these expenses are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

Travel and Lodging Expenses

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than seventy-five (75) miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-covered benefits for transportation and lodging include, but are not limited to:

1. Child care;
2. Mileage within the medical transplant Facility city;
3. Rental cars, buses, taxis, or shuttle service, except as specifically approved by us;
4. Frequent Flyer miles;
5. Coupons, Vouchers, or Travel tickets;
6. Prepayments or deposits;
7. Services for a condition that is not directly related, or a direct result, of the transplant;
8. Phone calls;
9. Laundry;
10. Postage;
11. Entertainment;
12. Travel costs for donor companion/caregiver;
13. Return visits for the donor for a treatment of an illness found during the evaluation; and
14. Meals.

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See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

Services related to non-human or artificial organs and their implantation.

Urgent Care Services

As described below you are covered for Urgent Care Services anywhere in the world. Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider's office or at an after-hours urgent care center.) Urgent Care Services are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature.

Inside the Service Area

We will cover charges for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area. You will not incur any additional cost sharing for Urgent Care Services beyond that which is indicated in your *Summary of Cost Shares*.

If you require Urgent Care Services, please call your primary care Plan Provider as follows:

If your primary care Plan Physician is located at a Plan Medical Office, please call:

1-800-777-7904

TTY 711

If your primary care Plan Physician is located in our network of Plan Providers, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

Outside the Service Area

If you are injured or become ill while temporarily outside the Service Area, we will cover charges for Urgent Care Services as defined in this section. You will not incur any additional cost sharing for Urgent Care Services beyond that which is indicated in your *Summary of Cost Shares*. All follow-up care must be provided by a Plan Provider or Plan Facility.

Bills for Urgent Care Services

If you are balance billed by an urgent care center for Urgent Care Services that were provided to you, simply mail a copy of the bill to us with your medical record number written on it. Your medical record number can be found on the front of your Kaiser Permanente identification card. Please mail your proof to us within one (1) year at the following address:

Kaiser Permanente National Claims Administration - Mid-Atlantic States

PO Box 371860

Denver, CO 80237-9998

For more information on the payment or reimbursement of covered Services and how to file a claim, see *Section 5: Filing Claims, Appeals and Grievances*.

If you obtain prior approval from Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or Medical Center in the Service Area, for continuing or follow-up treatment.

See the benefit-specific limitations and exclusions immediately below for additional information.

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<p>Benefit-Specific Limitations: We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.</p>	<p>Benefit-Specific Exclusions: Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.</p>
<p>Vision Services</p>	
<p>Medical Treatment We will provide coverage for Medically Necessary treatment for diseases of or injuries to the eye. Such treatment shall be covered to the same extent as for other Medically Necessary treatments for illness or injury.</p> <p>Vision Correction after Surgery or Accident We cover prescription glasses or contact lenses required as a result of surgery or for treatment of accidental injury. Includes cost of materials and fitting, exams, and replacement of eyeglasses or contact lenses if related to the surgery or injury. Eyeglass or contact lens purchase and fitting are covered under this benefit if:</p> <ol style="list-style-type: none"> 1. Prescribed to replace the human lens lost due to surgery or injury; 2. “Pinhole” glasses are prescribed after surgery for a detached retina; or 3. Lenses are prescribed instead of surgery due to; <ol style="list-style-type: none"> a. Contact lenses used for treatment of infantile glaucoma; b. Corneal or sclera lenses prescribed in connection with keratoconus; c. Scleral lenses prescribed to retain moisture when normal tearing is not possible or inadequate; or d. Corneal or sclera lenses are required to reduce a corneal irregularity other than astigmatism. <p>In addition, we cover the following Services:</p> <p>Eye Exams We cover routine and necessary eye exams for adults and children, including:</p> <ol style="list-style-type: none"> 1. One (1) routine eye examination per Calendar Year for children, including dilation if professionally indicated, at no charge; 2. Routine tests such as eye health and glaucoma tests for adults; and 3. Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses. <p>Exams performed in an Optometry Department will be subject to the Primary Care Copayment. Exams performed in an Ophthalmology Department will be subject to the Specialty Care Copayment, if different.</p>	

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Eyeglass Lenses

We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye. Children may receive one (1) pair of standard single vision, bifocal, trifocal or progressive eyeglass lenses per Calendar Year from a select group of lenses at no charge.

Frames

We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment. Children may receive one (1) pair of frames per Calendar Year from a select group of frames at no charge.

Contact Lenses

We provide a discount on the initial fitting for contact lenses at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

1. Fitting of contact lenses;
2. Initial pair of diagnostic lenses (to assure proper fit);
3. Insertion and removal of contact lens training; and
4. Three months of follow-up visits.

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time. Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.

In lieu of eyeglass lenses and frames, children may receive regular contact lenses once per Calendar Year at no charge. Fitting fee and initial supply (based on standard packaging for type purchased) are included. Medically necessary contact lenses for children are limited to two (2) pair per eye per calendar year at no charge.

Low Vision Services

Low vision services are covered for children. Low vision services include one comprehensive low vision evaluation every five (5) years, four (4) follow-up visits within any five (5) year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

See the benefit-specific exclusions immediately below for additional information.

Benefit-Specific Exclusions:

1. Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures;
2. Eye exercises;
3. Orthoptic (eye training) therapy;
4. Sunglasses without corrective lenses unless Medically Necessary;
5. Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section;

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6. Non-corrective contact lenses; and
7. Replacement of lost or broken lenses or frames.

X-Ray, Laboratory and Special Procedures

We cover the following Services only when they are prescribed as part of a preventive, diagnostic, or treatment Service covered under another heading in this section:

1. Diagnostic EKGs, EEGs;
2. Echocardiograms;
3. Diagnostic imaging and interventional diagnostic tests;
4. Laboratory and pathology services or tests, including tests for specific genetic disorders for which genetic counseling is available;
5. Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
6. Special procedures, such as electrocardiograms and electroencephalograms;
7. Sleep testing;
8. Sleep lab and sleep studies;
9. Specialty imaging, including CT, MRI, PET Scans, scans to evaluate and stabilize a patient with an emergency medical condition and diagnostic nuclear medicine studies;
10. Radiology including x-rays, mammograms, ultrasounds, and nuclear medicine;
11. BRCA screenings; and
12. Fetal screenings and other genetic testing.

We cover the following outpatient diagnostic imaging tools:

1. Magnetic resonance angiography (MRA);
2. Magnetic resonance imaging (MRI);
3. Magnetic resonance spectroscopy (MRS);
4. Computed tomographic angiography (CTA);
5. Positron emission tomography (PET) scans;
6. Computed tomography (CT) scans;
7. PET/CT Fusion scans;
8. QTC Bone Densitometry;
9. Diagnostic CT Colonography;
10. Single photon emission computed tomography (SPECT) scans; and
11. Nuclear cardiology.

Coverage includes professional Services for test interpretation, x-ray reading, lab interpretation and scan reading.

Note: See “Preventive Health Care Services” for coverage of lab and radiology Services that are part of preventive care screenings.

Exclusions

This provision provides information on what Services the Health Plan will not pay for regardless of whether or not the Service is Medically Necessary.

These exclusions apply to all Services that would otherwise be covered under this Agreement. Benefit-specific exclusions that apply only to a particular Service are noted in the List of Benefits in this section.

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When a Service is not covered, all Services, drugs, or supplies related to the non-covered Service are excluded from coverage, except Services we would otherwise cover to treat direct complications of the non-covered Service. The following Services are excluded from coverage:

1. Alternative Medical Services

- a. Acupuncture
- b. Holistic medicine
- c. Homeopathic medicine
- d. Hypnosis
- e. Aroma therapy
- f. Massage and massage therapy
- g. Reiki therapy
- h. Herbal, vitamin or dietary products or therapies
- i. Naturopathy
- j. Thermography
- k. Orthomolecular therapy
- l. Contact reflex analysis
- m. Bioenergetic synchronization technique (BEST)
- n. Iridology-study of the iris
- o. Auditory integration therapy (AIT)
- p. Colonic irrigation
- q. Magnetic innervation therapy
- r. Electromagnetic therapy
- s. Neurofeedback/Biofeedback.

2. Certain Exams and Services

Physical examinations and other Services:

- a. Required for obtaining or maintaining employment or participation in employee programs;
- b. Required for insurance, licensing, or disability determination; or
- c. On court-order or required for parole or probation.

3. Cosmetic Services

Cosmetic Services, including surgery or related Services for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies. Examples of Cosmetic Services include but are not limited to cosmetic dermatology, cosmetic surgical Services and cosmetic dental Services.

4. Court Ordered Testing

Court ordered testing or care unless Medically Necessary.

5. Custodial Care

Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. This exclusion does not apply to custodial care received while under hospice care.

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6. Dental Care

Dental care and dental x-rays, including dental appliances, dental implants, shortening of the mandible or maxillae for cosmetic purposes, and correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any non-removable dental appliance involved in temporomandibular joint (TMJ) pain dysfunction syndrome.

This exclusion does not apply to Medically Necessary dental care covered under “Accidental Dental Injury Services”, “Cleft-Lip, Cleft-Palate or Ectodermal Dysplasia”, or “Oral Surgery” in *Section 3: Benefits, Exclusions and Limitations*, or under “Dental Plans.”

7. Disposable Supplies

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices, not specifically listed as covered in *Section 3: Benefits, Exclusions and Limitations*.

8. Durable Medical Equipment

Except as covered under “Durable Medical Equipment” in *Section 3: Benefits, Exclusions and Limitations*, the following items and Services are excluded:

- a. Comfort, convenience, or luxury equipment or features;
- b. Exercise or hygiene equipment;
- c. Non-medical items such as sauna baths or elevators;
- d. Hydrotherapy equipment;
- e. Modifications to your home or car; and
- f. Electronic monitors of the heart or lungs, except infant apnea monitors.

9. Employer or Government Responsibility

Financial responsibility for Services that an employer or government agency is required by law to provide.

10. Experimental or Investigational Services

Except as covered under “Clinical Trials” in *Section 3: Benefits, Exclusions and Limitations*, a Service is experimental or investigational for your condition if any of the following statements apply to it at the time the Service is or will be provided to you:

- a. It cannot be legally marketed in the United States without the approval of the Food and Drug Administration (“FDA”) and such approval has not been granted; or
- b. It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- c. It is subject to the approval or review of an Institutional Review Board (“IRB”) of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- d. It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In determining whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

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- a. Your medical records,
- b. The written protocols or other documents pursuant to which the Service has been or will be provided,
- c. Any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- d. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- e. The published authoritative medical or scientific literature regarding the Service, as applied to your illness or injury, and
- f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

The Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

11. Family Members

Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

12. Health Club Memberships and Fitness Services

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even when ordered by a Plan Provider. This exclusion also applies to health spas.

13. Prosthetic and Orthotic Devices

Prosthetics for sports or cosmetic purposes. Services and supplies for external prosthetic and orthotic devices, except as specifically covered under Section 3 of this Agreement.

14. Routine Foot Care Services

Except for patients with diabetes or vascular disease as specifically covered under **Section 3: Benefits, Exclusions and Limitations**, the following foot care Services (palliative or cosmetic) are excluded:

- a. Flat foot conditions;
- b. Support devices and arch supports;
- c. Foot inserts;
- d. Orthopedic and corrective shoes not part of a leg brace and fitting;
- e. Castings and other services related to devices of the feet;
- f. Foot orthotics;
- g. Subluxations of the foot;
- h. Corns, calluses and care of toenails;
- i. Bunions except for capsular or bone surgery;
- j. Fallen arches;
- k. Weak feet; and

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1. Chronic foot strain or symptomatic complaints of the feet.

15. Travel and Lodging Expenses

Travel and lodging expenses, except that in some situations:

- a. If a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under “Getting a Referral” in Section 2: How to Get the Care You Need, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines; or
- b. If travel and lodging expenses are incurred as part of transplant services as described under “Transplant Services” in Section 3: Benefits, Exclusions and Limitations.

16. Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins, also known as spider veins, by any method including sclerotherapy or other surgeries for cosmetic purposes.

17. Workers’ Compensation or Employer’s Liability

Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as “Financial Benefit”), is provided under any workers’ compensation or employer’s liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:

- a. Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
- b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers’ compensation or employer’s liability law.

Limitations

We will make our best efforts to provide or arrange for your health care Services in the event of unusual circumstances that delay or render impractical the provision of Services under this Agreement, for reasons such as:

1. A major disaster;
2. An epidemic;
3. War;
4. Riot;
5. Civil insurrection;
6. Disability of a large share of personnel of a Plan Hospital or Plan Medical Office; and/or
7. Complete or partial destruction of facilities.

In the event that we are unable to provide the Services covered under this Agreement, the Health Plan, Kaiser Foundation Hospitals, Medical Group and Kaiser Permanente’s Medical Group Plan Physicians shall only be liable for reimbursement of the expenses necessarily incurred by a Member in procuring the Services through other providers, to the extent prescribed by the Commissioner of Insurance.

For personal reasons, some Members may refuse to accept Services recommended by their Plan Physician for a particular condition. If you refuse to accept Services recommended by your Plan Physician, he or she will advise you if there is no other professionally acceptable alternative. You may get a second opinion from another Plan Physician, as described under *Getting a Second Opinion* in *Section 2: How to Get the Care You Need*.

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SECTION 4: Coordination of Benefits

Medicare

If you are enrolled in Medicare, Medicare law may apply with respect to Services covered by Medicare.

Worker's Compensation Claims

If you have an active worker's compensation claim for injuries sustained while conducting the duties of your occupation, you must send written notice of the claim to us within thirty (30) days at the following address:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Patient Financial Services
2101 East Jefferson Street, 4 East
Rockville, Maryland 20852

When notifying us, please include the worker's compensation insurance company or third-party administrator (TPA) name, policy and claim numbers, business address and telephone number and, if known, the name of the handler of the claim.

If you are represented by an attorney in relation to the worker's compensation loss for which you have brought legal action against your employer, please ensure that provide your attorney's name and contact information, including their business address and telephone number. If you change attorneys during the legal process, you are required to inform the Health Plan of your change in representation.

Medicare and TRICARE Benefits

The value of your benefits are coordinated with any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law.

TRICARE benefits are secondary by law.

Coordination of Benefits

Coordination of Benefits Overview

Coordination of benefits applies when a Member has health care coverage under more than one (1) health benefit plan. If you or your eligible dependent has coverage under more than one (1) health benefit plan, then you are responsible to inform the Health Plan that the additional coverage exists. When you have other coverage with another health plan or insurance company, we will coordinate benefits with the other coverage.

The Health Plan may need information from you to coordinate your benefits. Any information that we request to help us coordinate your benefits must be provided to us upon request.

Right to Obtain and Release Needed Information

When information is needed to apply these coordination of benefits rules, the Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. The Health Plan does not need to tell nor obtain consent from any person to do this.

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Primary and Secondary Plan Determination

The health benefit plan that pays first, which is known as the primary plan, is determined by using National Association of Insurance Commissioners Order of Benefits Guidelines. The primary plan provides benefits as it would in the absence of any other coverage.

The plan that pays benefits second, which is known as the secondary plan, coordinates its benefits with the primary plan, and pays the difference between what the primary plan paid, or the value of any benefit or Service provided, but not more than one hundred (100) percent of the total Allowable Expenses, and not to exceed the maximum liability of the secondary plan. The secondary plan is never liable for more expenses than it would cover if it had been primary.

Coordination of Benefits Rules

To coordinate your benefits, the Health Plan has rules. The following rules for the Health Plan are modeled after the rules recommended by the National Association of Insurance Commissioners. You will find the rules under *Order of Benefit Determination Rules* in this section.

The *Order of Benefit Determination Rules* will be used to determine which plan is the primary plan. Any other plans will be secondary plan(s). If the Health Plan is the:

1. Primary Plan, it will provide or pay its benefits without considering the other plan(s) benefits.
2. A secondary Plan, the benefits or services provided under this Agreement will be coordinated with the primary plan so the total of benefits paid, or the reasonable cash value of the services provided, between the primary plan and the secondary plan(s) do not exceed 100 percent of the total Allowable Expense.

Members with a High Deductible Health Plan with a Health Savings Account option: If you have other health care coverage in addition to a High Deductible Health Plan with a Health Savings Account option (as described in *Section 1: Introduction to Your Kaiser Permanente Health Plan* under the *Health Savings Account-Qualified Plans* provision), then you may not be eligible to establish or contribute to a Health Savings Account Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.

Assistance with Questions about the Coordination of Your Benefits

If you have any questions about coordination of your benefits, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Order of Benefit Determination Rules

The following rules determine the order in which benefits are paid by primary and secondary health benefit plans.

1. If another plan does not have a Coordination of Benefits provision, that plan is the primary plan.
2. If another plan has a Coordination of Benefits provision, the first of the following rules that apply will determine which plan is the primary plan:

Rules for a Subscriber and Dependents

1. Subject to #2 (immediately below), a plan that covers a person as a Subscriber is primary to a plan that covers the person as a dependent.
2. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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- a. Secondary to the plan covering the person as a dependent; and
- b. Primary to the plan covering the person as other than a dependent:
 - i. Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Rules for a Dependent Child/Parent

1. **Dependent child with Parents who are not separated or divorced:** When the Health Plan and another plan cover the same child as a Dependent of different persons, called “Parents,” then the plan of the Parent whose birthday falls earlier in the year is primary to the plan of the Parent whose birthday falls later in the year. If both Parents have the same birthday, the plan that covered a Parent longer is primary. If the aforementioned parental birthday rules do not apply to the rules provided in the other plan, then the rules in the other plan will be used to determine the order of benefits.
2. **Dependent child with separated or divorced Parents:** If two (2) or more plans cover a person as a dependent child, and that child’s Parents are divorced, separated or are not living together, whether or not they have ever been married the following rules apply. If a court decree states that:
 - a. One (1) of the Parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that Parent has actual knowledge of those terms, that plan is primary. If the Parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that Parent’s Spouse does, that Parent’s Spouse’s plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision; or
 - b. Both Parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
 - c. If a court decree states that the Parents have joint custody without specifying that one Parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph #1 of this provision: ***Dependent Child with Parents Who Are Not Separated or Divorced***, shall determine the order of benefits; or
 - i. If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a) The plan covering the custodial Parent;
 - b) The plan covering the custodial Parent’s Spouse;
 - c) The plan covering the non-custodial Parent; and then
 - d) The plan covering the non-custodial Parent’s Spouse.

Dependent Child Covered Under the Plans of Non-Parent(s)

1. For a dependent child covered under more than one (1) plan of individuals who are not the Parents of the child, the order of benefits shall be determined, as applicable, under the dependent child provisions above, as if those individuals were Parents of the child.

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Dependent Child Who Has Their Own Coverage

1. For a dependent child who has coverage under either or both Parents' plans and also has his or her own coverage as a dependent under a Spouse's plan, the rule in this provision for ***Longer or Shorter Length of Coverage*** applies.
2. In the event the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both Parents' plans, the order of benefits shall be determined by applying the birthday rule in this provision under the ***Dependent Child with Parents Who Are Not Separated or Divorced***.

Active/Inactive Employee Coverage

1. A plan that covers a person as an employee who is neither laid off nor retired (or that employee's dependent) is primary to a plan that covers that person as a laid off or retired employee (or a laid off or retired employee's dependent).

COBRA or State Continuation Coverage

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree, or that covers the person as a dependent of an employee, member, subscriber or retiree, is the primary plan and the Plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

1. If none of the above rules determines the order of benefits, then the plan that has covered a Subscriber longer time is primary to the plan that has covered the Subscriber for a shorter time.

Effect of Coordination of Benefits on the Benefits of this Plan

When the Health Plan is the primary Plan, coordination of benefits has no effect on the benefits or services provided under this Agreement. When the Health Plan is a secondary Plan to one or more other plans, its benefits may be coordinated with the primary plan carrier using the guidelines below. This ***Coordination of Benefits*** provision shall in no way restrict or impede the rendering of services provided by the Health Plan. At the request of the Member or Parent/Guardian, when applicable, the Health Plan will provide or arrange for covered services and then seek coordination with a primary plan.

Coordination with the Health Plan's Benefits

The Health Plan may coordinate benefits payable or recover the reasonable cash value of Services it has provided, when the sum of the benefits that would be payable for:

1. Or the reasonable cash value of, the Services provided as Allowable Expenses by the Health Plan in the absence of this ***Coordination of Benefits*** provision; and
2. Allowable Expenses under one (1) or more of the other primary plans covering the Member, in the absence of provisions with a purpose like that of this ***Coordination of Benefits*** provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period.

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In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by the Health Plan may be recovered from the primary plan, so that the Health Plan benefits and the benefits payable under the other Plans do not total more than the Allowable Expenses.

Facility of Payment

If a payment is made or Service provided under another Plan, and it includes an amount that should have been paid for or provided by us, then we may pay that amount to the organization that made that payment.

The amount paid will be treated as if it was a benefit paid by the Health Plan.

Right of Recovery of Payments Made Under Coordination of Benefits

If the amount of payment by the Health Plan is more than it should have been under this *Coordination of Benefits* provision, or if we provided services that should have been paid by the primary plan, then we may recover the excess or the reasonable cash value of the services, as applicable, from the person who received payment or for whom payment was made, or from an insurance company or other organization.

Military Service

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs. When we cover any such Services, we may recover the value of the Services from the Department of Veterans Affairs.

Members with a High Deductible Health Plan with a Health Savings Account option who receive health benefits from the Department of Veterans Affairs: If a Member has actually received health benefits from the Department of Veterans Affairs within the past three (3) months, they will not be eligible to establish or contribute to a Health Savings Account, even when they are enrolled in a High Deductible Health Plan. Kaiser Permanente does not provide tax advice. Ask your financial or tax advisor about your eligibility.

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SECTION 5: Filing Claims, Appeals and Grievances

Getting Assistance

Member Services representatives are available to assist you at most of our Plan Medical Centers and by phone Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY). Member Services representatives will answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your Kaiser Permanente identification card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside our Service Area (see *Post-Service Claims*) or to initiate an Appeal for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your Primary Care Plan Provider or other health care professionals treating you. If you are not satisfied with your Primary Care Plan Provider, you can request a different Plan Provider by visiting our website www.kp.org or contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Who to Contact

If you have questions about how to file a claim, Appeal or Grievance with the Health Plan, please contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

To contact us in writing, mail or fax your correspondence to:

Kaiser Permanente
Attention: Appeals and Complaints Resolution
2101 E. Jefferson St.
Rockville, MD 20852
1-866-640-9826 (FAX)

When you must file a claim for services inside or outside of the Plan's service area, please submit claims to the following address:

Kaiser Permanente
National Claims Administration - Mid-Atlantic States
Attention: Claims Department
P.O. Box 371860
Denver, CO 80237-9998

Definitions

Adverse Decision: Any Health Plan determination or decision that:

1. A Service is not a covered benefit, or if it is a covered benefit, that such Service does not meet Health Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness and therefore payment is not provided or made by Health Plan, in whole or in part, for the Service, thereby making the Member responsible for payment of such Service, in whole or in part; or
2. Cancels or terminates a Member's membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

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Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant:

1. An Authorized Representative; or
2. The member's spouse, parent, committee, legal guardian or other individual authorized by law to act on the Member's behalf if the Member is not a minor but is incompetent or incapacitated.

Authorized Representative: An individual appointed by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals. Authorized Representative shall also include a Health Care Provider acting on behalf of a Member with the Member's express written consent, or without the Member's express consent in an Emergency situation. With respect to claims and appeals, the term "Member" shall include an Authorized Representative.

Complaint: A Complaint is an inquiry to the Member Services Department about Services, Member rights or other issues; or the communication of dissatisfaction about the quality of service or other issue which is not an Adverse Decision. Complaints do not involve utilization review decisions.

Concurrent Care Claim: A request that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either the course of treatment prescribed will:

1. Expire; or
2. Be shortened.

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Member's life or health or the Member's ability to regain maximum function. In determining whether an appeal involves Urgent Care, Health Plan must apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving:

1. Care that the treating physician deems urgent in nature;
2. The treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or
3. When Health Plan covers prescription drugs and the requested service is a prescription for the alleviation of cancer pain, the Member is a cancer patient and the delay would subject the Member to pain that could not adequately be managed without the care or treatment that is being requested.

Such Appeal may be made by telephone, facsimile or other available similarly expeditious method.

Explanation of Benefits (EOB): Any form provided by an insurer, health services plan or health maintenance organization which explains the amounts covered under a policy or Plan or shows the amounts payable by a Member to a health care provider.

Independent External Review: If the Member receives an Adverse Decision of an appeal, the Member or the Member's Authorized Representative, which may include the treating provider, may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Review.

Pre-Service Claim: A request that Health Plan provide or pay for a Service that you have not yet received.

Proof of Loss: All necessary documentation reasonably required by the Health Plan to make a determination of benefit or coverage.

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Post-Service Claim: A request for payment for Services you have already received, including but not limited to, claims for Out-of-Plan emergency services.

Urgent Medical Condition: As used in this Section 5, a medical condition for which care has not been rendered and which:

1. Could seriously jeopardize your life, health or ability to regain maximum function; or
2. Would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

Procedure for Filing a Claim and Initial Claim Decisions

When receiving Services outside of a Plan Medical Center, you will receive an Explanation of Benefits (EOB) within twenty-one (21) days of Proof of Loss. The EOB will describe the Services provided, whether the claim was paid or denied, the amount paid by Health Plan, your Cost Share, and the amounts accumulated toward meeting your Deductible (if applicable) and Out-of-Pocket Maximum. For Services furnished by Kaiser Permanente staff clinicians within a Plan Medical Center, EOBs will not be issued unless the Services provided are subject to a Deductible and/or Coinsurance.

The Health Plan will review claims that you file for Services or payment, and we may use medical experts to help us review claims and appeals. You may file a claim or an Appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and appeals related thereto, the term “Member” or “you” shall include an Authorized Representative, as defined above.

The Health Plan will also process a request for a standard review of a decision that a drug is not covered by the Plan for you or your Authorized Representative or the prescribing physician (or other prescriber).

The initial response of the Health Plan may be to request additional information from the prescribing provider in order to make a determination. Health Plan will make its utilization review decision no later than two (2) business days following receipt of all the information necessary to complete the review.

Health Plan will provide coverage of the drug for the duration of the prescription, including refills if the Health Plan grants a standard exception.

If you miss a deadline for filing a claim or appeal, we may decline to review it. If your health benefits are provided through an ERISA covered employer group, you can file a demand for arbitration or civil action under ERISA §502(a)(1)(B), but you must meet any deadlines and exhaust the claims and appeals procedures as described in this Section before you can do so. If you are not sure if your group is an ERISA group, you should contact your employer.

We do not charge you for filing claims or appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Office of the Managed Care Ombudsman, for which contact information is contained within this section, to obtain assistance.

Pre-Service Claims

Pre-Service Claims are requests that Health Plan provide or pay for a Service that you have not yet received. Our clinical peer will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or Appeal will become a Post-

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Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact our Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Procedure for Filing a Non-Urgent Pre-Service Claim

1. Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitutes your claim. You may write or call us at the address and number listed above.
2. We will review your claim, and if we have all the information we need we will communicate our decision within two (2) working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within fifteen (15) days of receipt of your claim. We encourage you to send all the requested information at one time so that we will be able to consider all of it when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will then make a decision within fifteen (15) days of the due date or the receipt date, whichever is earlier, based on the information we have.
3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.
4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
 - a. In writing within two (2) working days of the decision; or
 - b. Orally by telephone within twenty-four (24) hours of the decision if the claim is for cancer pain medication.

Note: The notice will include instructions for the provider on behalf of the member to seek a reconsideration of the Adverse Decision, including the name, address and telephone number of the person responsible for making the Adverse Decision.

5. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

Expedited Procedure for an Urgent Medical Condition

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service Claim.
2. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.
3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible taking into account your medical condition(s) but no later than twenty-four (24) hours after receiving your claim. We will send a written or electronic confirmation within three (3) days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within twenty-four (24) hours of receipt of your claim. You will have forty-eight (48) hours from the time of notification by us to provide the missing information. We will make a decision forty-eight (48) hours after the earlier of:

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- a. Our receipt of the requested information; or
 - b. The end of the forty-eight (48)-hour period we have given you to provide the specified additional information.
4. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can Appeal.
 5. When you or your Authorized Representative sends an Appeal, you or your Authorized Representative may also request simultaneous external review of our initial Adverse Decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See *Bureau of Insurance Independent External Appeals* in this section for additional information about filing an external Appeal.

Concurrent Care Claims

Concurrent Care Claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either the course of treatment prescribed:

1. Will expire; or
2. Be shortened.

Determinations regarding a Concurrent Care Claim request will be made, and notice provided to the Member's provider, by telephone and in writing, within one (1) business day of receipt of all information necessary to make a decision, but no later than fifteen (15) calendar days of receipt of the request.

1. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.
2. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to Appeal the decision as described below.

Concurrent Care Claims for an Urgent Medical Condition

If your Concurrent Care Claim involves an Urgent Medical Condition, and the claim is submitted within twenty-four (24) hours before the end of the initially approved period, we will decide the claim within twenty-four (24) hours of receipt.

If you filed a request for additional services at least twenty-four (24) hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, the Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances, but in no event later than thirty (30) calendar days from the date on which your claim was received.

1. If our clinical peer determines your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.

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2. We will notify you of our decision orally or in writing within twenty-four (24) hours after we receive your claim. If we notify you orally, we will send you a written decision within three (3) days after that.
3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can Appeal.
4. When you or your Authorized Representative sends the Appeal, you or your Authorized Representative may also request simultaneous external review of our Adverse Decision. If you want simultaneous external review, your or your Authorized Representative's appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the Appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the Appeal. See *Bureau of Insurance Independent External Appeals* in this section for additional information about filing an external appeal.

Post-Service Claims

Post-service Claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside our Service Area. If you have any questions about post-service claims or Appeals, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Procedure for Filing a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside our Service Area or other Services received from non-Plan Providers must be filed on forms provided by Health Plan; such forms may be obtained on our website, www.kp.org or by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

1. You must send the completed claim form to us at the address listed on the claim form within one-hundred eighty 180 days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments that may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.
2. We will review your claim, and if we have all the information we need we will send you a written decision within thirty (30) days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional fifteen (15) days to send you our written decision. If we tell you we need more time and ask you for more information, you will have forty-five (45) days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider all of it when we make our decision. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will make a decision based on the information we have. We will issue our decision within fifteen (15) days of the deadline for receiving the information.
3. If we deny your claim or if we do not pay for all the Services you requested, our written decision will tell you why we denied your claim and how you can Appeal.

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Reconsideration of an Adverse Decision

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request the review of an Adverse Decision by the Health Plan, on behalf of a Member. A request for reconsideration is optional. The treating provider may choose to skip this step, and you or your Authorized Representative may file an Appeal, as described below. If the provider does request reconsideration, the Member still has a right to Appeal.

The Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within ten (10) working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the Member's right to Appeal the decision as described below.

Appeals of Claim Decisions

The Appeal Procedures are designed by the Health Plan to assure that Member concerns are fairly and properly heard and resolved. By following the steps outlined below, Member concerns can be quickly and responsively addressed.

Standard Appeal

This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims. Please note that the timeframe for our response differs for Post-Service Claims (it is longer).

You or your Authorized Representative may initiate a standard appeal by submitting a written request, including all supporting documentation that relates to the Appeal to:

Kaiser Permanente
Attention: Appeals and Complaints Resolution
2101 East Jefferson Street
Rockville, MD 20852
866-640-9826 (FAX)

You or your Authorized Representative may request a standard Appeal by contacting the Member Services Department. In addition, you or your Authorized Representative, as applicable, may review the Health Plan's Appeal file and provide evidence and testimony to support the appeal request.

Wherever the term "Member" or "you" or "your" is used in this section, it shall include the Member's Authorized Representative.

The Appeal must be filed in writing within one-hundred eighty (180) days from the date of receipt of the original denial notice. If the Appeal is filed after the one-hundred eighty (180) days, the Health Plan will send a letter denying any further review due to lack of timely filing.

If within five (5) working days after a Member files an appeal, the Health Plan does not have sufficient information to initiate its internal appeal process, the Health Plan shall:

1. Notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided; and
2. Assist in gathering the necessary information without further delay.

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Standard appeals will be acknowledged within five (5) working days of the filing date of the written appeal request. An acknowledgement letter will be sent as follows:

Appeal of a Non-Urgent Pre-Service or Non-Urgent Concurrent Care Claim

If the Appeal is for a Service that the Member is requesting, the acknowledgment letter will:

1. Request additional information, if necessary;
2. Inform the Member when there will be a decision on their Appeal; and
3. State that written notice of the Appeal decision will be sent within thirty (30) days of the date the Appeal was received.

Appeal of a Post-Service Claim

If the Appeal is asking for payment for completed services, an acknowledgment letter is sent:

1. Requesting additional information, if necessary;
2. Informing the Member when a decision will be made;
3. That the Member will be notified of the decision within sixty (60) days of the date the Appeal was received.

If there will be a delay in concluding the Appeal process in the designated time, the Member will be sent a letter requesting an extension of time during the original time frame for a decision. If the Member does not agree to this extension, the Appeal will move forward to be completed by end of the original time frame. Any agreement to extend the Appeal decision shall be documented in writing.

If the Appeal is approved, a letter will be sent to the Member stating the approval. If the Appeal is by an Authorized Representative, the letter will be sent to both the Member and the Authorized Representative.

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information upon which the Health Plan made its decision. You or your Authorized Representative may also send additional information, including comments, documents, or additional medical records supporting the claim, to:

Kaiser Permanente
Attention: Appeals and Complaints Resolution
2101 E. Jefferson St.
Rockville, MD 20852
1-866-640-9826 (FAX)

If the Health Plan asked for additional information before and you or your Authorized Representative did not provide it, you or your Authorized Representative may still submit the additional information with the Appeal. In addition, you or your Authorized Representative may also provide testimony by writing or by telephone. Written testimony may be sent along with the Appeal to the address above. To arrange to give testimony by telephone, you or your Authorized Representative may contact the Appeals and Complaints Resolution Department. The Health Plan will add all additional information to the claim file and review all new information without regard to whether this information was submitted or considered in the initial decision.

Prior to the Health Plan rendering its final decision, it must provide you or your Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated (or at the direction of) by the Health Plan in connection with the informal Appeal.

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If during the Health Plan's review of the standard Appeal, it determines that an Adverse Decision can be made based on a new or additional rationale, the Health Plan must provide you or your Authorized Representative with this new information prior to issuing its final Adverse Decision. The additional information must be provided to you or your Authorized Representative as soon as possible and sufficiently before the deadline to give you or your Authorized Representative a reasonable opportunity to respond to the new information.

If the review results in a denial, the Health Plan will notify you or your Authorized Representative. The notification shall include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards on including interpretive guidelines, on which the Appeal Decision was based (including reference to the specific plan provisions on which determination was based);
3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized representative's claim.
4. A description of the right of the Member to file an external Appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an Appeal. An external Appeal must be filed within one-hundred twenty (120) days after the date of receipt of a notice of the right to an external review of a final Adverse Decision or an Adverse Decision if the internal Appeal process has been deemed to be exhausted or waived, a Member or their Authorized Representative may file a request for an external review in writing with the Commission of the date of the Health Plan's final Adverse Decision, as described below; and
5. A statement of your rights under section 502(a) of ERISA.

If we send you a notice of an Adverse Decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10 percent of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

If the Health Plan fails to make an Appeal Decision for a non-urgent pre-service Appeal within thirty (30) days or within sixty (60) days for a post-service Appeal, the Member may file a complaint with the Bureau of Insurance.

Expedited Appeal

When an Adverse Decision or adverse reconsideration is made, and you, your Authorized Representative, or treating health care provider believes that such Adverse Decision or adverse reconsideration warrants an immediate Expedited Appeal, you, your Authorized Representative, or your treating health care provider

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shall have the opportunity to Appeal the Adverse Decision or adverse reconsideration by telephone on an expedited basis.

An Expedited Appeal may be requested only when the regular reconsideration and Appeal process will delay the rendering of covered Services in a manner that would be detrimental to the Member's health.

You, your Authorized Representative, or your treating health care provider may initiate an Expedited Appeal by contacting Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY) during regular business hours. During non-business hours, please contact the Advice and Appointment Line at 703-359-7878.

Once an Expedited Appeal is initiated, our clinical peer will determine if the Appeal involves an urgent Pre-Service or Concurrent Care Claim. If the Appeal does not meet the criteria for an expedited Appeal, the request will be managed as a standard Appeal, as described above. If such a decision is made, the Health Plan will verbally notify the Member within twenty-four (24) hours.

If the request for Appeal meets the criteria for an expedited Appeal, the Appeal will be reviewed by a Plan physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual's subordinate) who made the initial Adverse Decision.

If additional information is needed to proceed with the expedited review, the Health Plan and the provider shall attempt to share the maximum information by telephone, facsimile, or otherwise to resolve the expedited Appeal in a satisfactory manner.

A decision with respect to such Expedited Appeal shall be rendered no later than:

1. Seventy-two (72) hours after receipt of the claim, if we have all of the necessary information; or
2. If the claim is for cancer pain medication, no later than twenty-four (24) hours after receipt of the claim.

If approval is recommended, the Health Plan will immediately provide assistance in arranging the authorized treatment or benefit.

If the Health Plan declines to review an Appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, the Health Plan shall immediately take the following actions:

1. Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard Appeal; and
2. Within twenty-four (24) hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to Appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an Appeal with the Bureau of Insurance, as described below.

The notification shall also include:

1. The specific factual basis for the decision in clear understandable language;
2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);

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3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request; and
4. A statement of your rights under section 502(a) of ERISA.

An Expedited Appeal may be further Appealed through the standard Appeal process described above unless all material information was reasonably available to the provider and to the Health Plan at the time of the expedited Appeal, and the physician advisor reviewing the Expedited Appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline related to the issues of the Expedited Appeal.

Bureau of Insurance Independent External Appeals

A Member may file for an Independent External Appeal with the State Corporation Commission's Bureau of Insurance:

1. If all of the Health Plan's Appeal procedures described above have been exhausted; or
2. If the Member's Adverse Decision involves cancer treatment or a medical condition where the timeframe for completion of an expedited internal appeal of an Adverse Decision would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function; or
3. If the Member requested an Expedited Appeal and Health Plan determined that the standard appeal timeframes should apply; or
4. When an Expedited Appeal is reviewed and is denied.

A member may request an expedited emergency review prior to exhausting our internal Appeal process if:

1. An Adverse Decision that was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;
2. The Health Plan fails to render a standard internal appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care provider has not requested or agreed to a delay; or
3. The Health Plan waives the exhaustion requirement.

An expedited emergency review for denials due to medical necessity, appropriateness, healthcare setting, level of care, or effectiveness may be requested simultaneously with an expedited internal review. The Independent Review Organization will review and determine if an internal appeal should be completed prior to expedited emergency review.

The forms and instructions for filing an emergency review are provided to the Member along with the notice of a final Adverse Decision.

To file an Appeal with the Bureau it must be filed in writing within one-hundred twenty (120) days from the date of receipt of your Health Plan decision letter using the forms required by the Bureau. The request is mailed to the following address:

VA-DP-OFFEX-BASE(01-20)

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Virginia State Corporation Commission
Bureau of Insurance
Life and Health Consumer Services Division
P. O. Box 1157
Richmond, VA 23218
804-371-9691 (Phone)
804-371-9944 (Fax)
www.scc.virginia.gov (Website)

The decision resulting from the external review will be binding on both the member and Health Plan to the same extent to which we would have been bound by a judgment entered in an action of law or in equity, with respect to those issues which the external review entity may review regarding a final Adverse Decision of Health Plan.

Office of the Managed Care Ombudsman

The Office of the Managed Care Ombudsman is available to assist Health Plan Members to file an appeal.

If a Member has questions regarding an appeal or grievance concerning the health care services that he or she has been provided which have not been satisfactorily addressed by the Health Plan, he or she may contact the Office of the Managed Care Ombudsman for assistance at:

Bureau of Insurance
Attention: Office of the Managed Care Ombudsman
P.O. Box 1157
Richmond, VA 23218
804-371-9032 (Phone)
1-877-310-6560 (Toll-free)
804-371-9944 (Fax)
E-Mail: ombudsman@scc.virginia.gov (Email)

The Office of Licensure and Certification

If a Member has concerns regarding the quality of care he or she has received, he or she may contact The Office of Licensure and Certification at:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Complaint Hotline:
804-367-2106 (Phone)
1-800-955-1819 (Toll-free)
804-527-4503 (FAX)

www.vdh.virginia.gov (Website)
mchip@vdh.virginia.gov (Email)

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Customer Satisfaction Procedure

In addition, the Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care services to Members. A written Complaint must be given or sent to a Members Services representative located at a Medical Office or by sending a letter to the following address:

Kaiser Permanente
Attention: Appeals and Complaints Resolution
2101 E. Jefferson St.
Rockville, MD 20852

You or your Authorized Representative will receive a written response to your complaints within thirty (30) days unless you or your Authorized Representative is notified that additional time is required.

If you are dissatisfied with our response, you may file a complaint with the Bureau of Insurance at any time.

For information visit the Bureau of Insurance's website at www.scc.virginia.gov or call the Life and Health Consumer Services Section at 804-371-9691 or toll-free 877-310-6560, to discuss your complaint or receive assistance on how to file a complaint. Written complaints may be mailed to:

Bureau of Insurance
Attention: State Corporation Commission
P.O. Box 1157
Richmond, VA 23218
804-371-9944 (FAX)

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SECTION 6: Change of Residence, Plan Renewal and Termination, and Transfer of Plan Membership

This section explains what to do when your location of residence changes and provides you with information on Plan renewal and termination, and transfer of Plan membership.

Change of Residence

If you move outside of the Health Plan's Service Area, you are no longer eligible for Health Plan coverage through the Exchange and your membership will be terminated as described below.

If you move to another Kaiser Foundation Health Plan region, you must promptly apply to a Health Plan Office or Exchange in that region to transfer your Membership. However, identical coverage may not be available in the new region.

Plan Renewal

This Plan is guaranteed renewable on an annual basis, subject to the redetermination of each Member's eligibility by the Exchange, depending on how you enrolled for coverage. Each Member that remains eligible for coverage following redetermination of eligibility shall remain enrolled under this Plan, unless the Member's coverage is terminated as described below.

Termination of Membership

Except as expressly provided in this section, all rights to Services and other benefits hereunder terminate as of the effective date of termination.

If your membership terminates, all rights to benefits end at 11:59 p.m. Eastern Time on the termination date. The membership of any Dependents will end at the same time that the Subscriber's membership ends. Members will be billed at Allowable Charges for any Services received following membership termination. The Health Plan and Plan Providers have no further responsibility under this Agreement after your membership terminates, except as provided under applicable law.

Termination of Agreement

This Agreement continues in effect from the effective date hereof and from month to month thereafter, subject to provisions in this section.

Termination by Member

The Subscriber may terminate this Agreement by written notice delivered or mailed to the Health Plan effective on a later date as specified in the written notice or at the end of the month in which the written notice is received by the Health Plan. In the event of termination, the Health Plan shall promptly return any unearned portion of the Premium Payment. The earned Premium Payment shall be computed pro rata. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

Termination Due to Nonpayment of Premium

Except for the first Premium Payment, if a Subscriber fails to pay any required Premium Payment when due according to *Section 1: Introduction to Your Kaiser Permanente Health Plan*, the Health Plan may terminate this Agreement. We will send written notice of the termination to the Subscriber at least thirty-one (31) days before the termination date (grace period). Coverage shall continue in force during the thirty-one (31) day grace period, prior to the termination date, unless written notice of discontinuance in accordance with the terms of this Agreement is received from the subscriber in advance of the date of

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discontinuance. If payment in full is received within the thirty-one (31) day period set forth in the written notice, then the Subscriber and Dependents shall continue to receive all benefits and Services covered under this Agreement. If payment is not received within the thirty-one (31) day period set forth in the notice, then this Agreement will be terminated at the end of the 31st day. In the event of termination under this provision, the Subscriber is liable for the pro-rata Premium for the time the contract was in force during the grace period.

Termination or Rescission for Cause

We may terminate or rescind your membership for cause if you:

1. Knowingly perform an act, practice or omission that constitutes fraud; or
2. Make an intentional misrepresentation of material fact.

If the fraud or intentional misrepresentation was made by the Subscriber, we may terminate the memberships of the Subscriber and all Dependents in your Family Unit. If the fraud or intentional misrepresentation was made by a Dependent, we may terminate the membership of the Dependent.

We will send written or electronic notice to the Subscriber or the Dependent at least thirty-one (31) days before the termination date. Such notice will include at minimum:

1. Identification of the alleged fraudulent act, practice, omission, or intentional misrepresentation of material fact;
2. An explanation as to why the act, practice, or omission was fraudulent or was intentional misrepresentation of material fact;
3. Notice that the covered person or their authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
4. A description of our internal appeal process for rescissions including any time limits applicable to those procedures; and
5. The date when the advance notice ends and the retroactive date to which the coverage will be rescinded.

We may report any Member fraud to the authorities for prosecution.

Discontinuation of a Product or All Products

We may discontinue offering a particular product or all products in a market, as permitted by law. If we discontinue offering in a market the product described in this Agreement, we will give ninety (90) days' prior written notice to the Subscriber. If we discontinue offering all products to groups in a market, we will give one hundred-eighty (180) days' prior written notice to the Subscriber.

Return of Pro Rata Portion of Premium in Certain Cases

If your rights hereunder are terminated under this section, prepayments received on your account applicable to a period after the effective date of termination are refunded to the Subscriber or Financially Responsible Person, as applicable. Amounts due on claims, if any, less any amounts due to the Health Plan, Plan Hospitals or Medical Group, shall be refunded to the Subscriber within thirty-one (31) days. In such cases, neither the Health Plan, Plan Hospitals, Medical Group nor any Physician has any further liability or responsibility under this Agreement.

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Age Limit/Misstatement of Age

This Agreement will continue in effect until the end of the period for which the Health Plan has accepted the payment if:

1. An individual Agreement establishes, as an age limit or otherwise, a date after which the coverage provided by the Agreement will not be effective and the:
 - a. Date falls within a period for which the Health Plan accepts a payment for the Agreement; or
 - b. Health Plan accepts a payment for the Agreement after the date specified in this section.

An equitable adjustment of payments will be made in the event the age of the Member has been misstated. The Health Plan's liability is limited to the refund, upon request, of the payment made for the period not covered by the Agreement if the age of the Member is misstated and according to the correct age of the Member the coverage provided by the Agreement would:

1. Not have become effective; or
2. Have ceased before the acceptance of the payment for the Agreement.

Transfer of Membership: Changing from Dependent to Subscriber Under a Kaiser Permanente for Individuals and Families Membership Agreement

A Member who has been enrolled as a Dependent under this Agreement but ceases to qualify as a Dependent for any reason except the reasons described above under "Termination for Cause" or "Termination for Non-payment", may enroll as a Subscriber under this Agreement within thirty-one (31) days after ceasing to qualify as a Dependent.

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SECTION 7: Other Important Provisions of Your Plan

This section contains additional special provisions that apply to this EOC.

Applications and Statements

Any applications, forms or statements specified in this Agreement, or that we request in our normal course of business, must be completed by you or your Authorized Representative or Financially Responsible Person, if applicable.

Assignment of Agreement

You may assign benefits, in writing, to a non-participating provider from whom you receive covered Services. A copy of this written assignment must accompany a claim for payment submitted by the non-participating provider. The claim for payment must be submitted to the Health Plan within six (6) months from the date of service.

If you receive a payment for covered Services received from a non-participating provider for which you have not already made payment, you are responsible for applying that Plan payment to the claim from that non-participating provider.

For ambulance Services, any person providing such Services to a Member under this Agreement may receive reimbursement for such Services directly from us upon submission of assignment of benefits within six (6) months from the date of service.

Attorney Fees and Expenses

In any dispute between a Member and the Health Plan or Plan Providers, each party will bear its own attorney fees and other expenses.

Contestability

The Health Plan may void this Agreement and/or deny any claim made hereunder on the basis of any statement or representation made by a Subscriber for a period of two years from the effective date of this Agreement. After this two-year period, Health Plan may void this Agreement and/or deny any claim made hereunder only on the basis of a statement that was material to the risk and contained in a written application or in the existence of fraud.

Contracts with Plan Providers

Plan Provider Relationship and Compensation

The relationship between the Health Plan and Plan Providers are those of independent contractors. Plan Providers are paid in various ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like additional information about the way Plan Providers are paid to provide or arrange medical and Hospital Services for Members, please refer to your Provider Directory or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Plan Provider Termination

If our contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence or loss of licensure status while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in

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excess of any applicable Cost Sharing for a period not to exceed ninety (90) days from the date we have notified you or your Parent/Guardian or Financially Responsible Person of the Plan Provider's termination.

Primary Care Plan Physician Termination

If our contract with your Primary Care Plan Physician terminates for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status while you are under the care of that Primary Care Plan Physician, you may continue to see that provider and we will retain financial responsibility for covered Services you receive in excess of any applicable Cost Sharing, for a period not to exceed ninety (90) days from the date we have notified you of the Plan Physician's termination, or until you have chosen a new Primary Care Plan Physician, whichever occurs first.

Governing Law

Any provision in this policy that conflicts with the requirements of any state or federal law relevant to this policy are automatically changed to satisfy the minimum requirements of such laws.

Legal Action

No legal action may be brought to recover on this Agreement:

1. Before the expiration of sixty (60) days after you have provided us with Proof of Loss in accordance with the terms of this Agreement; or
2. After the expiration of three (3) years from the date that Proof of Loss was required to be provided.

Mailed Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. You are responsible for notifying us of any change in address. Subscribers who move should promptly contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You may mail a change of address notice to the Health Plan by postage prepaid U.S. Mail to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 6831
2101 East Jefferson Street
Rockville, MD 20852-6831

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance use disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

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Overpayment Recovery

We may recover any overpayment we make for Services from:

1. Anyone who receives an overpayment; or
2. Any person or organization obligated to pay for the Services.

In the event of an overpayment to a Health Care Provider, we may only retroactively deny reimbursement to that Health Care Provider during the six (6)-month period after the date we paid a claim submitted by that Health Care Provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, the health care Services you receive, and payment for your health care. You may generally:

1. See and receive copies of your PHI;
2. Correct or update your PHI; and
3. Ask us for an account of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. We will not use or disclose your PHI for any other purpose without written authorization from you or your Authorized Representative, except as described in our *Notice of Privacy Practices*. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

You can also find the notice at your local Plan Facility or online at www.kp.org.

Refusal to Accept Treatment

While the Health Plan may not cancel or fail to renew a Member's enrollment in the plan due to the Member's refusal to follow a prescribed course of treatment, it may refuse to furnish certain further benefits or Services for a particular condition.

If a Member disagrees with a prescribed course of treatment, the Member shall be permitted to receive a second opinion from another participating provider. If the second participating provider disagrees with the prescribed course of treatment, the Health Plan may refuse to provide some of the Services for that particular condition, subject to the terms, conditions, limitations and exclusions of this Agreement and Health Plan's utilization review protocols and policies.

Surrogacy Arrangements

A surrogacy arrangement is an arrangement between a Member who becomes a surrogate mother/gestational carrier and another person or persons. In a surrogacy arrangement, you agree to become pregnant, then surrender the baby to another person or persons who intend to raise the child.

You must pay us charges for Services you receive related to conception, pregnancy or delivery in connection with a surrogacy arrangement (Surrogacy Health Services). Your obligation to pay us for

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Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within thirty (30) days of entering into a surrogacy arrangement, you must send written notice of the arrangement, including a copy of any agreement, the names and addresses of the other parties to the arrangement to:

Kaiser Permanente
Attn: Patient Financial Services Surrogacy Coordinator
2101 E. Jefferson St., 4 East
Rockville, MD 20852

You must complete and send us all consents, releases, authorizations, lien forms, assignments and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this provision and to satisfy those rights. You must not take any action that prejudices our rights.

If your estate, Parent, Guardian, Spouse, trustee or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, Parent, Guardian, Spouse or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

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Important Terms You Should Know

This section is alphabetized for your convenience. The terms defined in this section have special meanings. The following terms, when capitalized and used in this Agreement, mean:

A

Advance Premium Tax Credit (APTC): A tax credit based on estimated income that certain individuals who qualify can take to lower monthly payments for health insurance Premium. This definition only applies to plans offered on the Exchange.

Adverse Decision: A utilization review decision made by the Health Plan that:

1. A proposed or delivered Service is or was not Medically Necessary, appropriate or efficient; and
2. May result in non-coverage of the health care Service.

An Adverse Decision does not include a decision about the enrollment status as a Member under the Health Plan.

Agreement: The entirety of this EOC document, including all attached appendices, which constitutes the entire contract between a Member and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and which replaces any earlier Agreement that may have been issued to you by us.

Allowable Charges means either for:

1. Services provided by the Health Plan or Medical Group: The amount in the Health Plan's schedule of Medical Group and the Health Plan charges for Services provided to Members;
2. Items obtained at a Plan Pharmacy: The cost of the item calculated on a discounted wholesale price plus a dispensing fee;
3. All other Services: The amount:
 - a. The provider has contracted or otherwise agreed to accept;
 - b. The provider has negotiated with the Health Plan;
 - c. Stated in the Fee Schedule that providers have agreed to accept as payment for those Services;or
 - d. That the Health Plan pays for those Services.

Allowable Expense: (For use in relation to Coordination of Benefits provisions only, which are located in *Section 4: Coordination of Benefits*): A health care Service or expense, including Deductibles, Copayments or Coinsurance, that is covered in full or in part by any of the Plans covering the Member. This means that an expense or health care Service or a portion of an expense or health care Service that is not covered by any of the Plans is not an Allowable Expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense.

American Indian/Alaska Native: Any individual as defined in §4 of the federal Indian Health Care Improvement Act.

Appeal: A protest filed in writing by a Member or his or her Authorized Representative with the Health Plan under its internal Appeal process regarding a Coverage Decision concerning a Member. An Appeal does not include a verbal request for reconsideration of a benefit and/or eligibility determination.

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Appeal Decision: A final determination by the Health Plan that arises from an Appeal filed with the Health Plan under its internal Appeal process regarding a Coverage Decision concerning a Member.

Authorized Representative: An individual authorized in writing by the Member or Parent/Guardian, as applicable to act on the Member's behalf to file claims and to submit Appeals or Grievances to the Health Plan. A Health Care Provider may act on behalf of a Member with the Member's express consent, or without such consent.

C

Claim Determination Period: A Calendar Year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date this Coordination of Benefits provision or a similar provision takes effect.

Coinsurance: After you have met your Deductible, a percentage of Allowable Charges that you must pay when you receive a covered Service.

Copayment: A specific dollar amount that you must pay when you receive certain covered Services.

Cost Shares: The Deductible, Copayment or Coinsurance for covered Services, as shown in the *Summary of Cost Shares*.

Cost Sharing: Any expenditure required by or on behalf of a Member with respect to Essential Health Benefits. Such term includes Deductibles, Coinsurance, Copayments, or similar charges, but excludes Premiums, balance billing amounts for non-network providers, and spending for non-covered services.

D

Deductible: **This definition applies only to Members with health benefit Plans that require the Member to meet a Deductible.** The amount you must pay in a Calendar Year for certain Services before we will start paying benefits for those Services in that Calendar Year. See *Summary of Cost Shares* to find out which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. (For Dependent eligibility requirements see *Who Is Eligible* in *Section 1: Introduction to Your Kaiser Permanente Plan*.)

E

Emergency Case: A case in which an Adverse Decision was rendered pertaining to health care Services which have yet to be delivered and such health care Services are necessary to treat a condition or illness that, without immediate medical attention would:

1. Seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function; or
2. Cause the Member to be in danger to self or others.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the person's mental or physical health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

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2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: Health care Services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in any of the following:

1. Placing the person's mental or physical health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Essential Health Benefits provided within this Agreement are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

F

Family Coverage: Any coverage other than Self-Only Coverage.

Family Unit: A Subscriber and all of his or her enrolled Dependents.

Fee Schedule: A list of procedure-specific fees developed by Health Plan and which the Plan Provider agrees to accept as payment in full for covered Services rendered.

Filing Date: The earlier of five (5) days after the date of mailing or the date of receipt by the Health Plan when you mail information to us.

Financially Responsible Person or Guarantor: The person who contractually agrees to pay the Premium due. This definition only applies to Child Only Plans.

G

Grievance: A protest filed by a Member or Parent/Guardian, as applicable, or by a provider or other Authorized Representative on behalf of the Member, with the Health Plan, through our internal Grievance process regarding an Adverse Decision concerning the Member. A Grievance does not include a verbal request for reconsideration of a Utilization Review determination.

Grievance Decision: A final determination by the Health Plan that arises from a Grievance filed with us under our internal Grievance process regarding an Adverse Decision concerning a Member.

H

Habilitative Services: Health care Services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the

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expected age.

These services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of inpatient and/or outpatient settings, including, but not limited to applied behavioral analysis for the treatment of autism spectrum disorder.

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing Services or benefits for health care. The Health Plan is a Plan.

Health Savings Account: This definition only applies if you are enrolled in a qualified High Deductible Health Plan. It does not apply to Members with catastrophic Plan coverage. A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying Qualified Medical Expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, the Member must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with a financial or tax advisor for more information about your eligibility for a Health Savings Account. This definition only applies to High Deductible Health Plans.

High Deductible Health Plan: This definition applies only to Members with a High Deductible Health Plan. A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This definition only applies to High Deductible Health Plans.

Hospital: Any hospital:

1. In the Service Area to which a Member is admitted to receive Hospital Services pursuant to arrangements made by a physician; or
2. Outside of the Service Area for clinical trials, Emergency or Urgent Care Services or upon receiving an approved referral.

K

Kaiser Permanente: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Mid-Atlantic Permanente Medical Group, Inc. and Kaiser Foundation Hospital.

L

Limiting Age: The age at which an eligible dependent child loses eligibility for coverage. Under this Plan, the limiting age is 26, except for dependents with conditions of incapacity as provided under the *Who is Eligible* provision in *Section 1: Introduction to Your Kaiser Permanente Health Plan*.

M

Medical Group: Mid-Atlantic Permanente Medical Group, Inc.

Medically Necessary/Medical Necessity: Medically Necessary means that the Service is all of the following:

1. Medically required to prevent, diagnose or treat the Member's condition or clinical symptoms;
2. In accordance with generally accepted standards of medical practice;
3. Not solely for the convenience of the Member, the Member's family and/or the Member's provider; and

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4. The most appropriate level of Service which can safely be provided to the Member. For purposes of this definition, “generally accepted standards of medical practice” means:
 - a. Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - b. Physician specialty society recommendations; and/or
 - c. The view of physicians practicing in the Kaiser Permanente Medical Care Program.

Note: Unless otherwise required by law, we decide if a Service (described in *Section 3: Benefits, Exclusions and Limitations*) is Medically Necessary and our decision is final and conclusive subject to the Member’s right to Appeal, or go to court, as set forth in *Section 5: Filing Claims, Appeals and Grievances*.

Medicare: A federal health insurance program for people age 65 and older, certain disabled people and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this Agreement as a Subscriber or a Dependent, and for whom we have received applicable Premium. Members are sometimes referred to as “you” within this Agreement. Under no circumstances should the term “you” be interpreted to mean a Financially Responsible Person, Parent/Guardian or any other nonmember reading or interpreting this Agreement on behalf of a Member.

Minimum Essential Coverage: The type of coverage an individual needs to have to meet the individual responsibility requirement under the Patient Protection and Affordable Care Act.

O

Out-of-Pocket Maximum: The maximum amount of Deductibles, Copayments and Coinsurance that an individual or family is obligated to pay for covered Services per Calendar Year.

P

Parent/Guardian: The person who has legal authority to make medical decisions for a Member under age 19 or a Member age 19 or older who is incapable of making such decisions by reason of mental incapacity. This definition applies only to Child Only plans.

Plan: The health benefit Plan described in this Agreement.

Plan: (For use in relation to Coordination of Benefits provisions only, which are located in *Section 4: Coordination of Benefits*): Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. “Plan” does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis. “Plan” also does not include the medical benefits under an automobile policy, including benefits for personal injury protection. “Plan” also does not include:

1. Accident only coverage;
2. Hospital indemnity coverage benefits or other fixed indemnity coverage;
3. Specified disease or specified accident coverage;
4. School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four (24)-hour basis or on a “to and from school” basis;

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5. Benefits provided in long-term insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
6. Medicare supplement policies;
7. A state plan under Medicaid; or
8. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Plan Facility: A Plan Medical Center, Plan Hospital or another freestanding facility that is:

1. Operated by us or contracts to provide Services and supplies to Members; and
2. Included in the Signature provider network.

Plan Hospital: A Hospital that:

1. Contracts to provide inpatient and/or outpatient Services to Members; and
2. Is included in the provider network.

Plan Medical Centers: Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other Health Care Providers including non-physician Specialists employed by us provide Primary Care, specialty care and ancillary care Services to Members.

Plan Pharmacy: Any pharmacy located at a Plan Medical Office.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who:

1. Contracts to provide Services and supplies to Members; and
2. Is included in the Signature provider network.

Plan Provider: A Plan Physician or other Health Care Provider including but not limited to a non-physician Specialist, and Plan Facility that:

1. Is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program; or
2. Contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: The amount a Subscriber owes for coverage under this Agreement for his/her self and any covered Dependents; or for Child Only Plans, a Parent/Guardian or Financially Responsible Person.

Premium Payment(s): Periodic membership charges paid by the Subscriber.

Primary Care: Services rendered by a Health Care Practitioner in the following disciplines:

1. General internal medicine;
2. Family practice medicine;
3. Pediatrics; or
4. Obstetrics/gynecology (OB/GYN).

Q

Qualified Health Plan: Any health plan that has an effective certification that it meets the standards recognized by the Exchange through which such plan is offered. This definition applies only to plans offered on the Exchange.

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Qualified Medical Expenses: Amounts paid by an account beneficiary for medical care that qualifies under §213(d) of the Internal Revenue Code, for the individual, or his or her Spouse or Dependent for purposes of an HSA account.

S

Self-Only Coverage: Coverage for a Subscriber only, with no Dependents covered under this Agreement.

Service: A health care diagnosis, procedure, treatment or item.

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Prince William, Loudoun, Spotsylvania, Stafford; the following Virginia cities – Falls Church, Fairfax, Fredericksburg, Alexandria, Manassas and Manassas Park; the following Maryland areas: the City of Baltimore; the following Maryland counties: Baltimore, Carroll, Harford, Anne Arundel, Howard, Montgomery, and Prince George’s, and specific ZIP codes within Calvert, Charles, and Frederick counties. A listing of these ZIP codes may be obtained from any Health Plan office.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health care Services and is certified by Medicare. The facility’s primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Specialist: A licensed health care professional that includes physicians and non-physicians who is trained to treat or provide health care Services for a specified condition or disease in a manner that is within the scope of their license or certification. Specialist physicians shall be either board-eligible or board-certified.

Spouse: The person to whom you are legally married to in either a same- or opposite-sex marital relationship.

Stabilize: Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber. For Subscriber eligibility requirements, see the *Who is Eligible* provision in *Section 1: Introduction to your Kaiser Permanente Health Plan*.

U

Urgent Care Services: Services required as the result of a sudden illness or injury, which require prompt attention, but are not of an emergent nature.

Urgent Medical Condition: As used in *Section 5: Filing Claims, Appeals and Grievances*, a condition that satisfies either of the following:

1. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of the Health Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
 - a. Placing the Member's life or health in serious jeopardy;

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- b. The inability of the Member to regain maximum function;
 - c. Serious impairment to bodily function;
 - d. Serious dysfunction of any bodily organ or part; or
 - e. The Member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others.
2. A medical condition, including a physical, mental health or dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

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SECTION A: Outpatient Prescription Drug Benefit

The Health Plan will provide coverage for prescription drugs as described below.

Important Terms You Should Know

This section is alphabetized for your convenience. The terms defined in this section have special meanings. The following terms, when capitalized and used in this section, mean:

A

Allowable Charge: Has the same meaning as defined in the section *Important Terms You Should Know* in your Membership Agreement and Evidence of Coverage.

B

Brand Name Drug: A prescription drug that has been patented and is produced by only one (1) manufacturer.

C

Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Complex or Chronic Medical Condition: A physical, behavioral or developmental condition that:

1. May have no known cure;
2. Is progressive; or
3. Can be debilitating or fatal if left untreated or undertreated.

Complex or Chronic Medical Conditions include, but are not limited to: Multiple Sclerosis, Hepatitis C and Rheumatoid Arthritis.

Contraceptive Drug: A drug or device that is approved by the Food and Drug Administration (FDA) for use as a contraceptive and requires a prescription.

Copayment: The specific dollar amount that you must pay for each prescription or prescription refill.

F

Food and Drug Administration/FDA: The United States Food and Drug Administration.

G

Generic Drug: A prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as a Brand Name Drug.

L

Limited Distribution Drug (LDD): A prescription drug that is limited in distribution by the manufacturer or FDA.

M

Mail Service Delivery Program: A program operated by the Health Plan that distributes prescription drugs to Members via postal mail. Certain drugs that require special handling are not provided through the mail-delivery service. This includes, but is not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. Mail, and drugs that require professional administration or observation.

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Maintenance Medications: A covered drug anticipated to be required for six (6) months or more to treat a chronic condition.

Medical Literature: Scientific studies published in a peer-reviewed, national, professional medical journal.

N

Non-Plan Pharmacy: A pharmacy that has not contracted with the Health Plan, or the Health Plan's agent, to provide pharmacy services.

Non-Preferred Brand Drug: A Brand Name Drug that is not on the Preferred Drug List.

P

Plan Pharmacy: A pharmacy that is owned and operated by the Health Plan.

Preferred Brand Drug: A Brand Name Drug that is on the Preferred Drug List.

Preferred Drug List: A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is comprised of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Preferred Drug List based on a number of factors, including, but not limited to, safety and effectiveness as determined from a review of Medical Literature, Standard Reference Compendia and research.

Prescription Drug (Rx) Deductible: The amount, based on the Allowable Charge, that you must pay in a Calendar Year for covered Brand Name Drugs before you may purchase covered Brand Name Drugs for the rest of the Calendar Year, subject to the Copayment or Coinsurance listed in the *Summary of Cost Shares*, under "Copayment/Coinsurance."

R

Rare Medical Condition: A disease or condition that affects two-hundred thousand (200,000) individuals in the United States or approximately one (1) in one thousand, five-hundred (1,500) individuals worldwide. Rare Medical Conditions include, but are not limited to: Cystic Fibrosis, Hemophilia and Multiple Myeloma.

S

Specialty Drugs: A prescription drug that:

1. Is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition;
2. Costs \$600 or more for up to a thirty (30)-day supply;
3. Is identified as a specialty drug by the Health Plan's Pharmacy and Therapeutics Committee;
4. Is subject to dispensing limitations set by the Health Plan's Pharmacy and Therapeutics Committee in accordance with therapeutic guidelines based on Medical Literature, Standard Reference Compendia and research.

Standard Manufacturer's Package Size: The volume or quantity of a drug or medication that is placed in a receptacle by the maker/distributor of the drug or medication and is intended by the maker/distributor to be distributed in that volume or quantity.

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Standard Reference Compendia: Any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services, or the Commissioner.

Smoking Cessation Drugs: Over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.

Benefits

Except as provided in *Section 3: Benefits, Exclusions and Limitations*, we cover drugs, as described below, when prescribed by a Plan Physician, a non-Plan Physician to whom you have an approved referral, or a dentist. Each prescription refill is subject to the same conditions as the original prescription. A Plan Provider prescribes drugs in accordance with the Health Plan's Preferred Drug List. If the price of the drug is less than the Copayment, you will pay the price of the drug. You must obtain covered drugs from a Plan Pharmacy. You may also obtain prescription drugs using our Mail Service Delivery Program, for which you may obtain details at a Plan Pharmacy.

We cover the following prescription drugs:

1. FDA-approved drugs for which a prescription is required by law.
2. Compounded preparations that contain at least one ingredient requiring a prescription.
3. Self-injectable insulin. Supplies and equipment used to administer insulin are covered as described in *Section 3: Benefits, Exclusions and Limitations*, under the Diabetic Services benefit.
4. Flu shots and their administration.
5. Oral chemotherapy drugs.
6. Drugs that are FDA-approved for use as contraceptives and diaphragms at no cost. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to the Family Planning Services benefit in *Section 3: Benefits, Exclusions and Limitations*.
7. Off-label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature, as appropriate, in the treatment of the diagnosed condition.
8. Non-prescription drugs, when they are prescribed by a Plan Provider, and are listed on the Preferred Drug List.
9. Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency; or when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
10. Limited Distribution Drugs (LDD), regardless of where they are purchased, are covered the same as if they were purchased at a Plan Pharmacy.
11. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services (CMS) and if the:
 - a. Original prescription indicates additional quantities are needed; and
 - b. Refill requested does not exceed the number of refills indicated on the original prescription.
12. Any prescription drug approved by the FDA as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, nicotine patches and gum, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco.
13. FDA-approved drugs for which a prescription is required by law and for which there is not a non-prescription drug that is the identical chemical equivalent.

In the following circumstances, you can obtain an additional thirty (30)-day supply from your pharmacist:

1. You have lost your medication;
2. Your medication was stolen; or

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3. Your physician increases the amount of your dosage.

The Health Plan's Pharmacy and Therapeutics Committee sets dispensing limitations in accordance with therapeutic guidelines based on the Medical Literature, Standard Reference Compendia and research. The committee also meets periodically to consider adding and removing prescribed drugs on the Preferred Drug List. If you would like information about whether a particular drug is included in our Preferred Drug List, please visit us online at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_exchange_formulary.pdf

You may also contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY).

Where to Purchase Covered Drugs

Except for Emergency Services and Urgent Care Services, as defined in the section *Important Terms You Should Know* in your Membership Agreement and Evidence of Coverage, you must obtain prescribed drugs from a Plan Pharmacy or through the Health Plan's Mail Service Delivery Program, subject to the Cost Shares listed on the attached *Summary of Cost Shares* under Copayment/Coinsurance. Most non-refrigerated prescription medications ordered through the Health Plan's Mail Service Delivery Program can be delivered to addresses in MD, VA, DC and certain locations outside the Service Area.

Members may obtain prescribed drugs and accessories from either a Plan Pharmacy or a Non-Plan Pharmacy (or its intermediary) only if it has previously notified the Health Plan, by facsimile or otherwise, of its agreement to accept, as payment in full, a reimbursement for its Services at rates applicable to Plan Network Pharmacies, including any prescription Coinsurance consistently imposed by the Plan.

Services of Non-Plan Pharmacies

Notwithstanding any provision in this Agreement to the contrary, you have coverage for outpatient prescription drug services provided to you by a Non-Plan Pharmacy (or its intermediary) that has previously notified the Health Plan of its agreement to accept, as payment in full, reimbursement for its services at rates applicable to our Health Plan's Pharmacy network providers. This shall include any applicable Copayment, Coinsurance and/or Deductible (if any) amounts as payment in full, to the same extent as coverage for outpatient prescription drug services provided to you by Plan Pharmacies participating in our pharmacy network. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with the Health Plan or its designee within thirty (30) days of being requested to do so in writing by the Health Plan, unless and until the pharmacy executes and delivers the agreement.

If you have a prescription filled at a Non-Plan Pharmacy (or its intermediary), you must complete and submit a claim form. Reimbursement will be based on what a Plan Pharmacy would receive had the prescription been filled at a Plan Pharmacy. You will remain responsible for any applicable Copayment, Coinsurance and/or Deductible. If you have questions or need a claim form, visit www.kp.org or contact Member Services Monday through Friday between 7:30 a.m. and 9 p.m. at 1-800-777-7902 or 711 (TTY). This provision does not apply when prescription drugs are purchased from a Non-Plan Pharmacy that has agreed to accept reimbursement for its services at rates applicable to a Plan Pharmacy. In this case, you are not required to submit a claim for reimbursement.

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Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

We cover generic and brand name drugs, including those for specialty and biological drugs. Plan Pharmacies will substitute a generic equivalent for a Brand Name Drug when a generic equivalent is on our Preferred Drug List unless one of the following is met; The:

1. Provider has prescribed a Brand Name Drug and has indicated “dispense as written,” also sometimes referred to as “(DAW)” on the prescription;
2. Brand Name Drug is listed on our Preferred Drug List;
3. Brand Name Drug is prescribed by a:
 - a. Plan Physician;
 - b. Non-Plan Physician to whom you have an approved referral;
 - c. Dentist; and
 - i. There is no equivalent Generic Drug, or an equivalent Generic Drug has:
 - a) Been ineffective in treating the disease or condition of the Member; or
 - b) Caused or is likely to cause an adverse reaction or other harm to the Member.

The Health Plan will treat the drug(s) obtained as prescribed above as an Essential Health Benefit, including by counting any Cost-Sharing toward the Plan’s annual limitation on Cost-Sharing.

If you request a Brand Name Drug for which none of the above conditions has been met, you will be responsible for the Non-Preferred Brand Drug Cost Share.

Preferred Brand vs. Non-Preferred Brand Drugs

We cover preferred brand and non-preferred brand drugs, including those for specialty and biological drugs. Plan Pharmacies will dispense drugs from our Preferred Drug List unless the following criteria are met:

The Non-Preferred Brand Drug is prescribed by a:

1. Plan Physician;
2. Non-Plan Physician to whom you have a referral; or
3. Dentist; and
 - a. There is no equivalent drug in our Preferred Drug List; or
 - b. An equivalent Preferred Drug List drug has:
 - i. Been ineffective in treating the disease or condition of the Member; or
 - ii. Caused or is likely to cause an adverse reaction or other harm to the Member.

If you request a Non-Preferred Brand Drug, the Non-Preferred Brand Drug Cost Share will apply.

The Health Plan will treat the drug(s) obtained as prescribed above as an Essential Health Benefit, including by counting any Cost Sharing towards the Plan's annual limitation on Cost Sharing.

Dispensing Limitations

Except for Maintenance Medications and contraceptive drugs as described below, Members may obtain up to a thirty (30)-day supply and will be charged the applicable Copayment or Coinsurance based on the:

1. Prescribed dosage;
2. Standard Manufacturers Package Size; and
3. Specified dispensing limits.

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Drugs that have a short shelf life may require dispensing in smaller quantities to assure that the quality is maintained. Such drugs will be limited to a thirty (30)-day supply. If a drug is dispensed in several smaller quantities (for example, three (3) ten (10)-day supplies), you will be charged only one Cost Share at the initial dispensing for each thirty (30)-day supply.

Except for Maintenance Medications and contraceptive drugs, as described immediately below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a thirty (30)-day supply.

Maintenance Medication Dispensing Limitations

Members may obtain up to a ninety (90)-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider, or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on the:

1. Prescribed dosage;
2. Standard Manufacturer's Package Size; and
3. Specified dispensing limits.

Contraceptive Drug Dispensing Limitations

Members may obtain up to a twelve (12)-month supply of prescription contraceptives in a single prescription, when authorized by the prescribing Plan Provider or a referral physician.

Partial Dispensing of Medication

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance, if the following conditions are met:

- the prescribing physician or pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member; and
- the Member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the Member's prescription drugs.

Obtaining Reimbursement for Prescriptions Covered Outside the Service Area

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see Emergency Services and Urgent Care Services, as defined in the section *Important Terms You Should Know* in your Membership Agreement and Evidence of Coverage), or that are associated with a covered, authorized referral inside or outside of the Health Plan's Service Area. To obtain reimbursement, the Member must submit a copy of the itemized receipts for their prescriptions to the Health Plan. We may require proof that urgent or emergency care Services were provided. Reimbursement will be made at the Allowable Charge less the applicable Cost Share, as described in the *Summary of Cost Shares* section of this Agreement. Claims should be submitted to:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
P.O. Box 371860
Denver, CO 80237-9998

Limitations

For drugs prescribed by dentists, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy, unless the criteria for coverage of Non-

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Preferred Brand Drugs has been met. The Non-Preferred Brand Drugs coverage criteria is detailed in the above subsection titled *Preferred Brand vs. Non-Preferred Brand Drugs*.

In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department/our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply. However, a Member may file a claim for the difference between the Cost Share for a full prescription and the pro-rata Cost Share for the actual amount received. Instructions for filing a claim can be found in *Section 5: Filing Claims, Appeals and Grievances*. Claims should be submitted to:

Kaiser Permanente National Claims Administration - Mid-Atlantic States
P.O. Box 371860
Denver, CO 80237-9998

Exclusions

The following drugs are not covered under the Outpatient Prescription Drug Benefit. Please note that certain Services excluded below may be covered under other benefits in *Section 3: Benefits, Exclusions and Limitations*.

Please refer to the applicable benefit to determine if drugs are covered:

1. Drugs for which a prescription is not required by law, except for non-prescription drugs that are prescribed by a Plan Provider and are listed in our Preferred Drug List.
2. Compounded preparations that do not contain at least one (1) ingredient requiring a prescription and are not listed in our Preferred Drug List.
3. Take home drugs received from a hospital, Skilled Nursing Facility or other similar facility. Refer to Hospital Inpatient Care and Skilled Nursing Facility Care in *Section 3: Benefits, Exclusions and Limitations*.
4. Drugs that are considered to be experimental or investigational. Refer to Clinical Trials in *Section 3: Benefits, Exclusions and Limitations*.
5. Except as specifically covered under this Outpatient Prescription Drug Benefit, a drug:
 - a. That can be obtained without a prescription; or
 - b. For which there is a non-prescription drug that is the identical chemical equivalent (i.e., the same active ingredient and dosage) to a prescription drug, unless otherwise prohibited by state or federal laws governing Essential Health Benefits.
6. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.
7. Drugs or dermatological preparations, ointments, lotions and creams prescribed for cosmetic purposes including but not limited to drugs used to retard or reverse the effects of skin aging or to treat nail fungus or hair loss.
8. Medical foods. Refer to "Medical Foods" in *Section 3: Benefits, Exclusions and Limitations*.
9. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to Hospice Care in *Section 3: Benefits, Exclusions and Limitations*.
10. Prescribed drugs and accessories that are necessary for Services that are excluded under this Agreement.
11. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.

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12. Alternative formulations or delivery methods that are different from the Health Plan's standard formulation or delivery method for prescription drugs and deemed not Medically Necessary.
13. Drugs and devices that are provided during a covered stay in a Hospital or Skilled Nursing Facility, or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes the equipment and supplies associated with the administration of a drug. Refer to Drugs, Supplies, and Supplements and Home Health Services in *Section 3: Benefits, Exclusions and Limitations*.
14. Bandages or dressings. Refer to Drugs, Supplies, and Supplements and Home Health Services in *Section 3: Benefits, Exclusions and Limitations*.
15. Diabetic equipment and supplies. Refer to Diabetic Services in *Section 3: Benefits, Exclusions and Limitations*.
16. Growth hormone therapy (GHT) for treatment of adults age 18 or older, except when prescribed by a Plan Physician, pursuant to clinical guidelines for adults.
17. Immunizations and vaccinations solely for the purpose of travel. Refer to Outpatient Care in *Section 3: Benefits, Exclusions and Limitations*.
18. Any prescription drug product that is therapeutically equivalent to an over-the-counter drug, upon a review and determination by the Health Plan's Pharmacy and Therapeutics Committee. The determination by the Health Plan's Pharmacy and Therapeutics Committee is subject to appeal if the prescribing physician believes the over-the-counter therapeutically equivalent drug is inappropriate therapy for treatment of the patient's condition.
19. Drugs for weight management.
20. Drugs for treatment of sexual dysfunction disorder, such as erectile dysfunction.